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## ORIGINAL DEPARTMENT.

### LECTURE.

#### CLINICAL LECTURE.

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Lecturer on Obstetrics at Phila. Lying-in Charity, etc.

Reported by T. H. HUZZA.

GENTLEMEN: You will remember an interesting case of cancer of the *cervix uteri* upon which I operated two weeks ago, at which time the specimens were shown you by my colleague. You will remember I removed a large mass of diseased tissue, including most of the cervix up to the internal os, and also part of the posterior vaginal wall which the disease had invaded. The discharge was very offensive, and the mass removed was marked by a stench which makes the disease so horrible. After excising the diseased mass with curved scissors, the surfaces were thoroughly scraped to bring away as much of the affected tissues as was possible. There was left a large crater-shaped opening or cavity, which was carefully packed with cotton saturated with a 100 per cent. solution of chloride of zinc. The means and methods employed in packing the uterus were those suggested by Van de Warker, in the *Am. Jour. of Obstet.*, March, 1884. The nurse, with rubber stalls to protect her fingers, dipped balls of cotton the size of a hickorynut in the zinc solution and wrung them out. These balls were then carefully packed in with ordinary dressing forceps. There is danger here of causing fistula, as the recto-vaginal septum is very thin and the strong corrosive may penetrate the walls. When this is feared, you should reduce the zinc solution to the

strength of 50 per cent., which is sufficiently strong, and yet avoids danger of a troublesome fistula. In this case I used for the first forty hours rolls of cotton saturated with Monsel's solution, and well packed into the cavity. This prepares the parts for the zinc, and renders its action far more efficient. At the end of the time stated the cotton was carefully removed, any clots or shreds of tissue carefully cleaned out of the cavity, and I packed in the cotton saturated with the chloride of zinc, the 100 per cent. solution being used for the upper part, including the apex of the incision and the cavity of the uterus, while the 50 per cent. solution was used for the raw surface on the posterior vaginal wall. In eight or ten days, according to Van de Warker, the slough comes away without much trouble. This period was just two weeks in the present case.

We find, in this dreaded affection, three zones or areas of infected tissue. First is the site of the active disease. Around this is a zone in which are young cells, actively proliferating. The third zone is the part in which the process is just beginning. With chloride of zinc, all these parts may be sloughed out, and the third zone thoroughly removed, as could not be done by other means. You may slough away almost the whole uterus and its glands, which are especially dangerous points. There is no danger of septicæmia as chloride of zinc is a powerful antiseptic. There is no smell, a feature particularly marked in this case. When you remove the slough, be very careful not to pull on it, as there is danger of hemorrhage. Let it come away by its own weight, almost, using just enough force to

guide it. I tried the mass day before yesterday, but it would not come out easily, so I let it alone till this morning, when it was removed without difficulty. The mass of slough shows well the shape and size of the crater-like cavity, which was packed. Above we have the small connected mass corresponding to the size of the uterine cavity, as shown by measurement before packing.

This, gentlemen, illustrates an operation which has greatly ameliorated the condition of the patient, and, let us hope, has entirely eradicated the disease.

I have also to present a case in which you will be doubly interested, as illustrating the mechanism of labor in contracted pelves, and the subject of pelvimetry. The latter is neglected by obstetric teachers, or, if taught at all, is so treated that students gain little that is of practical use to them, and do not obtain ideas that will assist them in the diagnosis and management of such cases. The pelvimeter most commonly used is the instrument of Baudelocque. It is rather delicate and inconvenient. I prefer Matthews', as it is portable, efficient, and, I think, the best obtainable. It can be used, also, to examine the diameters at the outlet, as well as for ordinary external measurements. The scale extends from twenty inches one way to eight inches the other. The pelvimeter is used chiefly to measure externally, the internal means of measuring being with the finger.

This patient whom I bring before you has a height of only fifty inches. She presents distinct evidences of rachitis. You notice here the short forearm, the extremities of the bones being enlarged and thickened. The legs are bent, and the upper portions of the tibiae decidedly thickened. As a rule, you do not have in rickets the stature so much diminished. You will have a history of late dentition, the lower incisors often not being cut till the second year. The fontanelles will remain open a long time. You will usually find it was a cross, bottle-fed, dyspeptic infant. If you see the mother, she will probably tell you the child did not sleep well, would throw off its cover at night, and perspired profusely.

The pelvis, however, is very marked in its changes, and if carefully observed can hardly be mistaken. Now you will ask me what measurements are to be taken in order to distinguish it from the normal pelvis. First we take the distance between the anterior superior spines of the ilia, which should be about 10½ inches. Next we find the measurement between the iliac crests, which is

11½ inches. Bear in mind this relationship, for upon it depends the character of the case you may wish to determine. If this relation or ratio is found, you know it is not rachitic. The third measure is the external conjugate, or diameter of Baudelocque. This should be about 8 inches. These are the only measurements that are of any practical importance, and the only ones that need be taken. To attain them the patient should be placed on a hard surface, preferably on a table. A spring-bed is the worst thing possible, as the hips sink in and you cannot reach the spines or crests. Now, letting our patient lie on her back, I will take the first measurement, which is the distance between the anterior superior spines of the ilia. It is here 9½ inches. Now for the distance between the crests. In the normal pelvis we find the crests easily, but here they are not distinct. Instead of spreading out as you go back from the spines, we find the crests go back here almost in a straight line. This feature is to be carefully noted. As we cannot find the widest points, we have a rule in such pelves, *i. e.*, measure two inches posterior to point where anterior spines were measured. We find the second measurement here to be 9½ inches. At once we would say this was rickets, as we find the normal relation disturbed. In marked cases the distances between crests may be less than that between the spines. Here we find the distance between the anterior-superior spines is very little less than normal, but we find the ratio changed. This is the important point. Now we turn the patient on her side, and take the third measurement. Searching for the fossa below the spine of the last lumbar vertebra, and placing one arm of the pelvimeter on this point, the other arm upon the anterior superior margin of the pubic symphysis, we here find the external conjugate to be 6½ inches. The early investigators of this subject thought it would be easy by subtracting so much from this to obtain the internal or true conjugate. Not so; the value of it is chiefly in the inference you can draw, and the after examination it leads you to make.

I need not further illustrate on this patient the method of internal measurement, but will explain the principles on this Budin manikin. We have here a movable sacrum, which I will screw up so as to make the true conjugate three inches. Now, take your right hand, with the index and middle fingers extended, the others folded back in the palm, and the patient being on her back with thighs well flexed, introduce it into the

vagina and press well up till you feel the promontory of the sacrum. Marking the position of the subpubic ligament with the forefinger of the left hand, withdraw your fingers and measure the distance you have. It is, you see, three and three-fourths inches. But this is the oblique conjugate which we know bears a fixed relation to the true conjugate. In the normal pelvis the latter is about three-fourths of an inch less than the oblique. We measure the true conjugate on the manikin and find it is three inches exactly. This relation varies in contracted pelves. The inclination and depth of the pubic symphysis may change it. So may the height of the sacral promontory. In rachitic pelves we must subtract a little more than three-fourths of an inch to obtain the true conjugate. In the Mütter Museum at the College of Physicians I examined very carefully the specimens of contracted pelves which are there, and in every one I found it was necessary to subtract one inch from the oblique to obtain the true conjugate.

We found the distance between the spines was nine and one-half inches. This shows that the transverse diameter of the pelvis is about normal. This is to be carefully noted, for if we have plenty of room in the transverse diameter it enables us to deliver where otherwise it would be impossible. The normal true conjugate is four inches, but not till the pelvis is narrowed below three and one-half inches in this measurement is it to be considered a contracted pelvis. Yet a woman of this measurement may pass through labor, and I feel certain that they do very commonly, yet the diminished diameter is not observed. But there is a great difference between the mechanism in a normal case and in *flattened rachitic pelvis*, as this is. The head comes down in the transverse diameter. It is not flexed, as is ordinarily the case, but is semi-extended. The anterior fontanelle is usually in reach, and it is perfectly proper that it should be so. We do not want the head flexed in these cases, as the bi-parietal diameter must pass to one side with one parietal boss, the anterior on a lower plane than the posterior, the so-called Naegele obliquity. It is possible where the pelvis is three and one-half inches in the true conjugate for a woman to give birth to a child unassisted. I have seen a woman give birth to a child by means of the forceps I show you here, my modification of Tarnier's traction forceps, and yet the true conjugate was less than three inches, and the child weighed eight pounds. This woman has been delivered twice; each time the child was dead. It is,

therefore, not only justifiable, but it is our duty to induce labor prematurely. In this way we give the child a better chance, and also greatly diminish the risks to the mother. The true conjugate in this case has been shown by repeated examinations to be three inches. We shall induce labor, as near as possible at the thirty-fourth week. The result you shall know in due time. I had intended to review the means to be used and the many points connected with the subject, but as my time will not allow it, I shall postpone these until our next meeting.

## COMMUNICATIONS.

### SOME RECENT STUDIES AND OBSERVATIONS ON TINNITUS AURIUM.

BY LAURENCE TURNBULL, M. D., PH. G.,

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(Continued from page 360.)

*Tinnitus from Stomach and Liver Disturbance.*—We have already referred to disturbance of the stomach in which vomiting may cause tinnitus, more especially in woman during pregnancy. In a recent paper by Dr. E. Ménière (*Revue Mensuelle de Laryngologie, d'Otologie, etc.*, June, 1886), he claims that tinnitus may be produced without deafness, due to disease of the stomach alone. In most of our cases there has been more or less impairment of hearing with catarrhal disease of the mucous membrane of the middle ear, causing vascularity and reflex action of the trophic and vaso-motor nerves extending from the stomach to the auditory nerve. Some cases may be accounted for on the theory that the tinnitus is due to the swelling and reflex action in the post-nasal spaces, middle ear, and orifice of the eustachian tubes, by extra secretion of mucus, desquamative epithelium, etc. The air being excluded from the middle ear the stapes is driven inwards, increasing the tension upon the labyrinth fluids. Dr. Ménière refers to the theory of Woakes in support of his conclusions that stomach tinnitus in such cases is due to an affection of the internal ear, which is chiefly supplied by the vertebral artery and a branch of the pneumogastric nerve, and any disturbance is reflected to the latter, the calibre being increased, causing passive congestion of the labyrinth.

The following are two cases of this form of tinnitus, reported by my assistant, Dr. Jones, Aural Clinic, Jefferson:

Case 1. John B. E., age 47. H. D. normal. No discharge. Tinnitus (roaring), two weeks' duration; left ear. Treatment: Hydrarg. chlor. mite gr.  $\frac{1}{2}$  every half hour for six hours, followed by Seidlitz powder. Full recovery in three days.

Case 2. J. O'Neil, age 44. H. D. normal. M. T. normal. No discharge. Tinnitus roaring. Two weeks' duration. Right ear. Due to alcohol. Treatment: Hydrarg. chlor. mite gr.  $\frac{1}{2}$  every half hour for six hours, followed by a saline.

Both these cases were caused by a prolonged debauch.

*Treatment.*—Static electricity has also been found of benefit, and we can confirm this statement (see method of using in Manual of Diseases of the Ear, new ed., 1887, p. 537). Bromide of potassium in large doses; but great care must be given to the stomachic digestion by the selection of proper food, use of pepsin, etc.

*Gouty or Rheumatic Inflammation of the Ear followed by Deafness, by Peculiar Dry, Rubbing, Tinnitus Aurium.*—Case 1. While in London we were called in consultation with Dr. Shilletteo, to see a gentleman who had been for several years a sufferer from severe attacks of gout, with deposits of salts of phosphate of lime in various parts of his body. He had become gradually deaf, and desired his physician to call in a specialist to see what could be done for his relief. We examined his ears, and found a deposit of the lime salts in the membrana tympani in points. There was but little pain, and peculiar dry, rubbing tinnitus aurium.

The treatment we recommended was the free use of the iodide of potassium in ten-grain doses three times a day, in water, while a weak warm solution of the same was dropped carefully into the ear, to act upon the layer of the membrane. The Politzer's air-douche was also employed to free the eustachian tube from mucus. After a treatment of several weeks we were pleased to be informed that the deafness had disappeared, much to the comfort of the patient.

*Rheumatic Otitis.*—Case 2. June 11, 1885. Mrs. A. P. C., æt. 41. Has suffered from hereditary deafness for years, increasing within the last four years. Five members of her family are very deaf. She resides in a malarious and damp region in the vicinity of a river. She has suffered at times with a dull headache and slight but never decided chill, which could be termed a true shaking ague. Has had several severe attacks of rheumatism, and during the attack she lost

her hearing and for a time was completely deaf. After the free use of bicarbonate of potassium, the pain left her, and she was also relieved of her temporary deafness. These attacks have left her with more or less pain at times in the nape of the neck. Membrana tympani opaque, sunken, and a deposit of lymph, etc. She has also the same form of tinnitus. The tuning-fork is heard best in contact with the mastoid, showing some involvement of the labyrinth, etc. What is to be done with this class of cases? Restore as far as possible the parts involved by local and general measures, but above all change in climate for the patient, for we have found that a change from the vicinity of Chester say to New Mexico, or some such change, improves the hearing, while a return to the old locality again brought a return of the deafness. Again, a removing from Pennsylvania to St. Paul, Minnesota, modified and improved the chronic middle ear catarrh.

*Tinnitus Aurium of Cerebro-Spinal Meningitis and Diseases of the Teeth.*—In the early course of cerebro-spinal meningitis, there is an almost constant complaint of roaring and ringing in the ears, followed by earache, hallucinations of hearing, and soon after by deafness. Ringing in the ear (tinnitus) is commonly enough caused by a diseased condition of the dental organs; and where no immediate cause is found to explain the condition, the teeth are to come in for a full share of attention. As constitutional conditions, predisposing to or exciting the condition, may be enumerated anemia, continual constipation, disease of the stomach and liver, and various diseases of the brain. Many cases of tinnitus that have long baffled the ordinary attempts at cure have disappeared almost immediately on the extraction of a diseased tooth never thought of in this connection.

*Patulous Condition of Eustachian Tube.*—In this class of cases, which are generally the result of a relaxed condition of the orifice of the Eustachian tube, the remedy should be the application of a strong solution of nitrate of silver or sulphate of copper or carbolic acid and glycerine to the mouth or faucial orifice of the tube, and subsequently washing it, by the use of the double Eustachian catheter, with the internal use of strychnia, to stimulate the muscle to contract and close the orifice.

*The "Aspergillus."*—This is often a cause of tinnitus aurium. It is a vegetable parasites or fungus, and is to be removed by the injection of absolute alcohol, or a warm so-

lution of sulphite of sodium. This mould is best seen by the use of the microscope, and can be cultivated on an apple or lemon. The discharge of serous fluid is to be checked by the use of an injection of a strong solution of sulpho-carbolate of zinc or nitrate of silver. A number of these cases of a mild character we have treated after the summer season in patients who have allowed the seawater to pass into the ears and dampen the hair, or in those who work in damp earth. In these cases a mild solution of an astringent, acetate or sulphate of lead or sulphate of zinc, will remove all the symptoms of itching, deafness, and distressing tinnitus in a very short time.

*On the Use of Cocaine and Brucine in Tinnitus Aurium and Painful Affections of the Ears.*—Our personal experience with hydrochlorate of cocaine has been quite extensive, and we consider it a valuable remedy in certain forms of tinnitus aurium. It facilitates catheterization of the eustachian tube, when closed by spasmodic action, or when filled with mucus, serum, etc., by the applying of a two or four per cent. solution to the lower nasal passages and the pharyngeal orifice of the tube. Injections of solution of cocaine alone, or followed soon by atropine, morphine, etc., will, by their contracting and sedative action on the blood-vessels, dilate the calibre of the canal, facilitate inflation of the middle ear, and permit injections, gases or liquids to pass into the tube and the tympanic cavity. The buccal and pharyngeal mucous membranes are readily and rapidly anesthetized by cocaine. All operations on the mucous membrane of the middle ear, pharynx, epiglottis, and larynx, generally considered so painful, are rendered almost painless by its local application, if the drug is pure. Instillations of cocaine into the external auditory meatus in cases of neuralgic earache have been found useful by many reliable observers. So, also, on the acute earaches in children, i. e., Kinnicutt, Thomas, Reder, Landesberg, and many others.

We have performed perforation of the membrana tympani in three cases with entire absence of pain under the influence of cocaine.

The application of painful remedies in acute and chronic purulent otitis, as, for instance, nitrate of silver, sulphate of zinc and copper, chromic acid, alcohol, ether, can be done after cocaineization with almost entire relief of pain. Also operations on the walls of the auditory canal, caustic applications to the auricle, and tumors, can be removed with

but little pain by subcutaneous injections of cocaine.\*

Kirchner (*Deutsche Med. Woch.*, No. 4, 1885,) finds that with twenty per cent. solution of cocaine he is able to produce anaesthesia in operations on the membrana tympani.

Tufal (*Prüger Med. Woch.*, No. 7, 1885,) has obtained similar good results. (This is on the healthy membrane, not the inflamed and elevated one ready to break.)

We have instilled a few drops of a four per cent. solution of cocaine into the ear in tinnitus aurium consequent upon chronic otitis media, with the result of lessening both the tinnitus and deafness.

M. George Viau has solved the problem of local anaesthesia in minor surgery and dentistry. After numerous trials of solutions of different strengths, he has found that the soft parts about the maxillae may be rendered completely insensible by the use of cocaine associated with a two per cent. solution of pure carbolic acid. Five minutes before operation, M. Viau dissolves five centigrammes (one grain) of hydrochlorate of cocaine in fifty centigrammes (ten drops) of the solution, and injects it into the gums, half-way between the neck and the extremity of the root of the tooth. Half of the solution is injected on the palatine and the remainder on the labial side, pressure being made by the finger, when the needle is withdrawn, to prevent the exit of the fluid. Anaesthesia is perfect in three minutes. The quantity of cocaine advised by M. Viau seems somewhat large, but it has been so used in eighty-seven cases without causing any unpleasant symptoms.

We have made several experiments with this combination (crystallized carbolic acid and cocaine), and can confirm the results obtained by Professor Viau.† The pure carbolic or phenic acid of the French should be Calvert's pure, crystallized and dissolved in distilled water.

*Brucine, its Local Use as an Anaesthetic in Diseases of the Ear.*—We have received from the author‡ a valuable reprint of some interesting experiments on the use of cocaine and brucine as anaesthetics on the skin and mucous membranes. He states, however, that the latter is not as prompt as the cocaine in

\*Turnbull, L. Hydrochlorate of cocaine in acute otitis causes deafness from coryza (Author's Work on Cocaine, Philadelphia, 1885, MEDICAL AND SURGICAL REPORTER, rep., Philadelphia, April, 1885, Manual of Diseases of the Ear, second edition, 1887.

†De l'Anesthésie Locale (pamphlet, p. 23), Officier d'Académie, Professor of School and Hospital Dentaires de Paris.

‡Dr. Thomas I. Mays, Philadelphia, Therapeutic Gazette, June, 1885.

the same strength. It is, however, on the cutaneous surface where its action is most decided and definite. This is best demonstrated by applying (in solutions of 5 to 20 per cent.) to the hairy parts of the hands and arms, and allowing it to remain for ten or fifteen minutes, and then comparing the sensibility of the skin thus treated with a neighboring point by pulling out the hair." As brucine is always contaminated by strychnine, we have felt unwilling to use an inferior anæsthetic for fear of poisoning the patient. We received a specimen free from strychnine from Dr. May, and employed it in a number of experiments, and the following is an abstract of them in diseases of the ear. To make the solution soluble, it requires five drops of hydrochloric acid to the gramme, which would prevent its use in eyesurgery, etc.

With a five per cent. solution of brucine we find that, although it may be more lasting in its effects than cocaine, it is not so sure to produce them, and we think not so readily absorbed. We found it of no service when applied to the skin, but will relieve the pain of irritant applications to mucous surfaces, and generally give relief in cases of furuncles of the external auditory canal and suppurative otitis media. In a few instances, after liberal applications to the nasal cavities, the patient felt uncomfortable for some hours, evidently from the strychnine-like effects of the drug.

**Labyrinthine Tinnitus Aurium.**—If this be severe and persistent, leeches in front of the ear are to be recommended. Large doses of bromide of potassium and ammonia, tincture gelsemium, hydrastin, and valerianate of zinc have also been found useful by Dr. Field in tinnitus in general.

This most distressing and persistent form of tinnitus, which depends upon disease of the labyrinth, may be, as we have shown, in many instances, from reflex irritation, which must be cured by the removal of the cause. There are many cases in which the noises are from an acute or chronic inflammation of the labyrinth proper, and there are but few agents which cause much impression upon this portion of the nervous system of the ear. The remedy which has yielded the best results is pilocarpine, the active principle of *jaborandi*.\*

**Hydrobromic Acid** has been claimed by Dr. Woakes as a "specific remedy for congestive labyrinthine conditions, provided always that the auditory apparatus be free from any well marked process which by its

presence might tend to keep up increased vascular action." This agent was first employed by Wade,\* who claimed that the acid "possesses all the valuable properties of potassium bromide, but lacks its influence on the heart and muscular system;" but this is a mistake, as it was proven by the careful experiments of Professor Edward T. Reichert, of the University of Pennsylvania,† *i. e.*, that it certainly does affect the heart the same as potassium bromide, and as he has conclusively proven, it depresses the muscles, and ultimately paralyzes the heart.

I give a summary of the conclusions drawn from the results of present research, placed for convenient reference in a parallel column, with the conclusions arrived at by the different investigators on the action of the "potassium bromide," representing the physiological action of the alkaline salts.

#### HYDROBROMIC ACID.

**The Circulation: Arterial Pressure.**—The arterial pressure is unaffected by very small doses, or a slight rise occurs: moderate doses cause an increase from the first, or a diminution of pressure, followed by a return to or above the normal; large doses cause the pressure to fall, and if sufficient, cause it to fall to zero.

The fall of pressure is due to a depression of the heart muscle.

The rise of pressure to a constriction of the vaso-motor peripheries.

#### POTASSIUM BROMIDE.

**Arterial Pressure.**—Administered hypodermically it causes diminished arterial tension, with increased pulse frequency. Large doses paralyze the heart, and thus reduce arterial pressure (I. G. Schonten, Archiv der Heilkunde, xii., 2. 1871; Schmidt's Jahr., Bd. c. liv.)

(See above.)

**Vaso-motor peripheries** irritated, causing constriction (Lewinsky, Virchow's Archiv, Bd. xlv. p. 191; Amory, The Phys. and Ther. Action of Bromide of Potassium, Boston, 1872; Meuriot, L'étude de la Belladone, p. 49; Saison, Schmidt's Jahr., Bd. cxliii.) This action on the capillaries has been denied.

**Pulse.**—After slow intravenous injection of a two per cent. solution of the potassium bromide, the pulsations become slower and feebler, the blood pressure falls, and the heart is finally arrested. Hypodermically injected, the pulse-rate is increased with diminished arterial pressure and diminished pulse-curves. Large doses paralyze the heart (Schonten, loc. cit.; Eulenbergh and Guttman, Virchow's Archiv, xii., 1867).

**Pulse.**—The pulse-rate is not appreciably affected by very small doses; moderate doses, on the contrary, cause a momentary slowing by inhibiting the heart, the pulse then recovering to a variable extent, and being followed by a gradual fall; or, a momentary rise occurs accompanied by a diminution of arterial pressure, this being followed by a diminution to below the normal; or, after large and repeated doses the pulse falls below normal and then becomes exceedingly rapid, or becomes rapid from the first; or may be depressed from the first. All these effects being due to a direct cardiac action, with the above single exception. The increased pulse-rate being attended with a diminution of pressure and small pulse-curves.

**Nervous System: Cerebrum.**—Consciousness in the higher

**Cerebrum, Spinal Cord and Nerves.**—"The evidence is, I

\* Wade, Peninsular Journal of Medicine, February, 1875, p. 62.

† Hydrobromic Acid, its Action on the Circulatory and Nervous System, Boston Med. and Surg. Journal, June 2, 1881.

\* See Manual of Diseases of Ear Cases, chapter xxii., new ed., 1887.

mammals present until near death. *Spinal Cord.*—The sensory portions of the spinal cord are the first portions of the reflex apparatus to be paralyzed, and reflex paralysis is due to this cause. The motor portions of the cord are depressed, as well as both the sensory and motor nerves.

*Muscular System.*—The muscular system is depressed.

think, sufficient to prove that bromide potassium affects all parts of the nervous system of the lower animals, but that the cerebrum, the motor tract of the cord, and the efferent nerves, are the last portions to be affected; that the most sensitive is the receptive (sensory) portion of the cord and next to this are the peripheral ends of the sensory nerves." (H. C. Woods' Therapeutics, 1879, p. 825.

*Muscular System.*—Depressed. (Papers quoted.)

In small and repeated doses the remedy acts upon and relieves what is termed pulsating tinnitus, but in true labyrinthine tinnitus it has but little influence, not acting as an emunctory either of the skin, glands, or kidneys. The dose is fifteen drops of the strong acid well diluted, but with care it can be increased to sixty drops; it should always be given in an abundance of syrup and water, and to prevent dyspeptic symptoms should be combined with a bitter tonic, etc.

(To be continued.)

## NON-SPECIFIC FUNGOID GROWTH OF THE VULVA.

BY T. WALLACE SIMON, M. D.,

Of Philadelphia.

On the 3d of June, 1884, I was called to see Mrs. McK—, a young woman, recently married (about a year), not yet pregnant.

I, and my father before my time, had attended her and her husband, and both their families, and there was no trace whatever of constitutional or specific syphilitic history in either family.

Mrs. McK—, a bright, healthy, and intelligent young Irish woman, aged nineteen, complained of what she called an eruption on the "privates," with great pain in copulation, with soreness, itching, and burning pain after the act, and a smarting, burning pain in micturition. Her husband also corroborated her statements, and said that the eruption she complained of made their sexual relations both painful and unpleasant.

On examination, I found both the greater and lesser labia completely covered with a fungoid growth, racemose in character, running down to and past the fourchette, on to the anus. It was blood-red in color, and grew as thick and close as cauliflower, very much resembling the latter in its form and shape. It grew as high from the surface as one-quarter of an inch; and on separating the tufts of the growth, an apparently healthy skin was disclosed below.

This seemed to me a very unusual case. I searched my library in vain for a parallel, and came to the conclusion to treat it in my own way. Here was a great mass of fungoid, mushroom growth, reaching from the mons veneris all the way down to the anus, and extending beyond the labia, somewhat on the thighs on either side.

First, I attempted (with Drs. S. C. McClure and Isaac Barton in consultation) the laborious task of separating each tuft and ligating at the base, hoping to strangulate it, but found it would not answer the purpose. Nor would it have been possible to cut off the growth with the knife close to the surface. So I adopted the following plan, which, it seems to me, was unique in itself, and which I have not seen described in any work on tumors or adventitious growths of this part, and I think should merit recording.

On my next visit to the patient, I took a stout pair of forceps—the teeth of which fitted perfectly down to the point, which was rather broad and flat at the end—and went over the greater part of the growth at the first operation, pinching each separate tuft of the growth, down at the surface of the skin, until I could feel the teeth of the two blades of the forceps "grit" together, thus practically strangulating the growth and cutting off its blood-supply. The tufts did not come off with the forceps, but hung loose and pendulous after the nipping process. This was almost entirely bloodless.

I then painted the tufts that I had strangulated with a mixture of Monsell's solution and iodine. In three operations I had strangulated all the growth in this way, and in a few days the growth had nearly all dropped off on the napkins the patient wore, and in about two weeks there was a clean surface of healthy skin without a vestige of the growth remaining.

Within one year from the time of the operation I delivered Mrs. McK. of a fine healthy child, and there was then no trace whatever of the old growth, or any sign of a return of it, the skin being perfectly clean and healthy, no scar remaining.

I scarcely know what to term such a growth. If it was a *non-specific adenoma*, I do not remember having heard of, nor have I seen recorded, a similar case.

—A citizen of Iona, Mich., while standing with wet rubbers on an iron doorstep, suddenly lost the power of walking. He nearly fainted from terror, thinking he was paralyzed. Upon discovering that his rubbers were frozen to the doorstep he felt better.

## MEDICAL SOCIETIES.

## OBSTETRICAL SOCIETY OF PHILADELPHIA.

*(Concluded from page 365.)*

Dr. Longaker thought it far better to turn the fetus by the bipolar method before rupturing the membranes or perforating the placenta. He had attended a lady in her first labor at the age of thirty-seven years. She was seized with profuse hemorrhage while walking in the street. When called, he found placenta prævia; the os was open to the size of the index finger, and large clots were in the lower segment of the uterus. He turned the child by the bipolar method, passed two fingers through the placenta, brought one leg through and left the case to nature. The child was lost as the entire placenta was attached low down, placenta prævia centralis, and retraction of the uterus, interfered with utero-placental circulation. In a second case, turning was followed by a similar result in a case of placenta prævia centralis. While the two children were lost, both mothers recovered without an unfavorable symptom. In three cases, respectively of lateral marginal and partial placenta prævia, treated by rupture of membranes, and application of forceps in one of them, two children were lost. In one of these cases the foetal heart-sounds were extinct on my arrival, half an hour after a sudden and profuse hemorrhage. All the mothers did well. The high fetal mortality shows that we cannot place much value upon the child's life, and in view of the dangers which threaten the mother's life, would it not be best to interfere promptly when called to a case of hemorrhage from this cause regardless of the age of the fetus?

Dr. M. Price inquired of Dr. Longaker how the feet could come through the placenta unless he first passes his hand through to make a hole? When the thighs and breech come down they serve the purpose of an efficient tampon.

Dr. Longaker replied that version being first accomplished, the hand is passed into the vagina and two fingers through the placenta can find the foot.

Dr. H. A. Kelly exhibited a placenta prævia centralis of the seventh month of pregnancy, in which he had perforated the placenta to break the amnion, and after turning, delivered, saving the mother, who had suffered from profuse hemorrhages. He described a case in which turning had proved

impossible in a placenta prævia lateralis owing to the fact that the cord was so tightly wrapped around the child's neck that only a small bight was left between the head and placenta, and when the foot was brought out at the vulva the head was felt fixed at the brim as at first. The foot was returned and a forceps delivery of the head revealed the difficulty, which was corrected, and the mother delivered of a seven-months' baby, which died immediately. The mother made a perfect recovery. No one rule suits all cases. The first point of importance in event of free hemorrhage is to rupture the membranes, and this must not be a mere fracture, but as free a separation as possible along the placental margin. The hemorrhage comes from the separation of the uterine and placental surfaces, and this is only to be prevented by freeing the placenta on one margin so that as the contraction ring goes up, the placenta may, as far as possible, ascend with it. Turning is only needed in the more urgent cases. Where the pains are strong and the hemorrhage has been but moderate, let the head engage and more children will be saved.

He urged more care in the classification of cases, for when the diagnosis is made early through an os but moderately dilated, and placental tissue felt every where, the diagnosis of a central implantation is often made, which attention to the later development of the case will show, through a fully-opened os, to be partial.

The tampon, also, should be given up, for, unless scientifically applied, it is utterly useless; it introduces great danger of sepsis, and with the best applied tampon in the absence of the necessary counter-pressure above in the uterus, in the very cases in which it is used, the dangers of concealed hemorrhage are imminent. If the bleeding has been great, bring on active labor, but don't use the tampon. Finally, and most important, every case should be treated by thorough antiseptic measures owing to increased septic susceptibility.

Dr. Parvin remarked that the classification of placenta prævia that had been given was incomplete; it did not include all the facts, for instead of two there are four varieties of the disorder. Thus we have not only central and partial, but also marginal and lateral implantation of the placenta when this organ is prævia, and it is prævia whenever it occupies a portion of the womb, which must be dilated to permit the passage of the child. Manifestly, the results, both as to maternal and fetal mortality, will be very different in different varieties.

It is a mistake to assert that the tampon treatment of placenta prævia has been abandoned. Very many eminent French obstetricians, for example, in certain cases, employ the tampon, and the cases will be referred to again. That the tampon permits concealed hemorrhage is an old objection which has gained nothing by time; it is a sort of bugbear that does not frighten obstetricians who have used the tampon, for where it is properly applied, the membranes being unruptured, bleeding, either internal or external, to any serious amount, is impossible. Indeed, if the uterus be properly compressed through the abdominal wall, and the tampon well applied, serious hemorrhage from placenta prævia, even after the rupture of the membranes, is impossible. That septicæmia is peculiarly liable to occur in cases where there has been placenta prævia has been for some time generally recognized, this liability arising, not from the position of the placenta, but from the manipulations, the consequence of such position.

Now in violent cases of hemorrhage resulting from placenta prævia is the tampon advisable? Blundell has stated that in one night he was called to two women far advanced in pregnancy, both dead from uterine hemorrhage, and then refers to some cases of such flooding where removal of the child could be more readily effected by the Cæsarian operation, so slightly dilated and so resistant was the os uteri. The most natural treatment of a hemorrhage occurring with an undilated os is arrest of the flow by pressure, that is by the application of the tampon; such treatment may be available in some cases where no other can be so readily applied. We are indebted more especially to Wigand for the first clear and complete exposition of the tampon treatment in placenta prævia, and his testimony as to the value of his method, first uttered probably one hundred years ago, was very strong, for he declared that in suitable cases and properly used, no death of mother or child occurred. Müller, whose elaborate monograph upon placenta prævia is so well known to those who have studied this subject, has given a qualified but still a positive endorsement of the tampon as the proper means to employ in certain cases and at a certain stage of the hemorrhage, that is when the cervix is undilated. There have been cases in the hands of both Pajot and Bailly, left, as was Wigand's practice, after the thorough tamponing, to nature, the further progress of the labor being undisturbed by art. Murphy has been the most successful among recent

obstetricians in the treatment of placenta prævia; and his method is the induction of premature labor, with partial detachment of the placenta and the use of Barnes's dilators. But it is to be observed that the dilators act as tampons by their pressure arresting the flow of blood. Certainly the remarkable success which has attended Murphy's method in his own hands, especially the low maternal mortality which he has secured, speaks strongly in favor of the general adoption of that method. In reporting cases of placenta prævia it seems to me very important, in order that we may compare similars, to know the variety of the disorder in each instance. The practitioner who, for example, successfully for both mother and child, conducts a case of lateral implantation of the placenta has accomplished no wonderful achievement. We cannot arrive at a certain knowledge unless the materials for induction are properly classified. One word more. Some skepticism has been expressed as to the possibility, or rather practicability of combined internal and external version in cases of placenta prævia; but as this has been accomplished, it is hardly a question for discussion.

Dr. Price's cases were at full term. He had not taken premature cases into his account. Deliveries at five, six, and seven months, the fetus not being viable, admit different principles. Emptying the uterus as early as possible is safer for the mother.

#### Pelvic Measurement.

Dr. H. A. Kelly called the attention of the Society to an external direct method of measuring the conjugata vera which he had found of extreme value in a large number of non-pregnant gynecological cases which had come to him complaining of difficulties since a previous confinement.

The short vagina or cellulitis or cicatricial contractions often prevent the finger in the vagina from reaching the promontory. In a case he had examined in the morning, the short vagina prevented the vaginal finger reaching the promontory while the outside hand rested upon it, and on pressing deeper felt the vaginal fingers fully three centimetres below. This case was measured by the outside hand, and determined normal. Another case had a rachitic pelvis 8½ centimetres conjugate. She had borne ten children at term through difficult labors, but without assistance.

The method is simple, avoids a vaginal examination in the virgin, is invaluable in many cases retrospectively and prognostically. The inaccuracy of the external con-

jugate is well known. This, of course, is of no use in the most important class of cases, the advanced pregnant, but it does often afford invaluable facts in other cases.

The method is to press deeply with the finger-tips of the extended hand until the promontory of the sacrum is felt, then by slipping the fingers up and down over this until the relations are well appreciated, let the fingers rest vertically above the angle, and at the same time mark on the palm with the finger of the other hand the position of the posterior surface of the symphysis, also vertically below. This measurement from the mark thus made to the tip of the finger is the conjugata vera thus directly measured.

Dr. Montgomery, in a paper entitled **Tracheotomy and Intubation in Diphtheria**, urged the importance of early operation. The symptom which should indicate the necessity for operation was depression of the substernal region during inspiration. This symptom indicates the inefficient entrance of air to fill the lungs, and the diaphragm becomes a fixed point depressing the soft tissues. The longer this condition continues the greater the danger of collapse of portions of lung tissue. The large mortality after tracheotomy and intubation is due to the postponement of operative interference in the majority of cases until these changes have occurred. This assertion is verified by his own experience in tracheotomy. In his first ten cases, in all but one of which the operation was done as a last resort, none recovered. In the next seven cases in which excepting two, it was done early, five recovered. The two fatal cases were not considered hopeful at the time of operation. His eighteenth case died before the trachea was opened. Of the last ten, five recovered—twenty-eight cases, with ten recoveries. He has practiced intubation in thirteen cases with six recoveries. All but one of these cases were seen in consultation, and some of them were in a dying condition when intubation was practiced. In no case did death occur in less than twenty-four hours, and in all the relief from dyspnea was prompt and permanent. The youngest child was eighteen months of age, and died on the fifth day of convulsions. The youngest child to recover was set. two years. In one case of recovery tracheotomy was performed the day following the intubation. A smaller size tube than suited for its age had been used; the dyspnea recurring, and the tube absent from the glottis, it was feared that it had been passed into the trachea. It was found that the tube was coughed up and swallowed

and passed per anum two days later. Of course in this case little can be claimed for intubation. He prefers intubation to tracheotomy, and believes that the former will supplant the necessity of doing the latter. The advantages are: it is free from danger, it requires no cutting nor anæsthetic, the after-treatment does not require skilled attention, as the air is moistened and warmed by the natural passages before entering the trachea, there is therefore no dry mucus accumulating in the tube, and not the same danger of secondary inflammatory lesions. As the tube does not fill up the calibre of the trachea, membrane is coughed up around instead of through it, and thus the danger of blocking is avoided.

Dr. Joseph Price presented to the Society a framed engraving, a portrait of Dr. Emmett, of New York.

W. H. H. GITHENS, *Secretary*.

#### THE NEW YORK NEUROLOGICAL SOCIETY.

Stated meeting, February 1, 1887. The President, C. L. Dana, M. D., in the chair. Dr. C. L. Dana reported a case of

**Pachymeningitis Hemorrhagica, with Large Meningeal Hemorrhage Pressing Chiefly on Leg Centre—Right Hemiplegia, Total Paralysis in Leg, Aphasia, Hemi-anæsthesia, Convulsions Limited to Arm and Face—Death—Exhibition of Specimen.**

The patient was a woman about sixty-eight years old, and came into the hospital with complete motor aphasia, and unable to give any previous history. She had no paralysis at first; but three days after admission she had a general convulsion, followed by right hemiplegia; total in the leg, and some right-sided anæsthesia. On the second and third days she had a series of brief localized convulsions involving the face bilaterally and the right arm. These were carefully observed. The movements were clonic, beginning in the muscles of the lower jaw. The other peculiarities were these:

1. The pupils remained small during the convulsions. When wider convulsive centres are discharging, as in general epileptic convulsions, the pupils are dilated. It is not probable that in this case there was some uræmic element, because the post-mortem disclosed a sufficient cause for them.

2. The conjugate deviation of the eyes was at first, and very temporarily, toward the side of the lesion, and away from the paralyzed side. The head, also, was turned toward this side. When this occurs, it is ordi-

narly spoken of as a paralytic deviation. This does not explain it here since almost immediately the head and eyes were turned strongly to the opposite and paralyzed side.

The speaker suggested that the first deviation is due to an inhibition of the activity of the associated nuclei of the third and sixth nerves that innervate the external and internal recti of the two eyes. There are many facts which tend to show that the first stage of convulsion is a transient paralysis due to a sudden discharge of inhibition centres. These are of a higher, more developed class than the centres for motor discharges, and would be affected first. We would have then, loss of consciousness, inhibition of motion, and muscular relaxation; then motor discharges and tonic and clonic convulsions.

3. The temperature on the paralyzed side was one degree higher than normal, and higher by a degree than that of the other side. This is the rule in intra-cerebral hemorrhage and hemiplegia, but the speaker was not aware that it has been established in cortical hemiplegias. In meningeal hemorrhages the temperature is often below normal according to Minot.

4. The presence of hemi-anæsthesia.

The patient died on the third day. Post-mortem showed chronic pachymeningitis over both convexities, but more on the left side. On the left convexity there was a very extensive fresh meningeal clot pressing upon and flattening especially the upper half of the central convolutions. Brain substance normal.

**Cortical Epilepsy with Temporary Asphasia.  
Syphilitic Gumma Compressing the Left  
Second Frontal Convolution in Its  
Lower Posterior Part.  
Recovery.**

Dr. M. Allan Starr related the history of the case. Charles S., aged thirty-two, had always been healthy and a hard worker. He had an attack of sciatica four years ago, and three years ago had a hard chancre. He had never had convulsions or nervous affection. Family history good. During November, 1886, and the first two weeks of December, he did not sleep well, was slightly dizzy, his head ached a good deal, chiefly at night. December 15, while walking with a pail in his right hand, he suddenly let it drop, losing all power in the hand and arm. There was numbness in the hand. He was unable to speak to his companions. He did not feel dizzy or notice any pain in the head; he did not lose consciousness nor fall. He understood his friends' questions, but could

not answer. Power in the hand and arm, and speech returned within half an hour. The next morning he went to work, as well as usual. Two days later a second attack occurred, beginning with a numb feeling in the tips of the fingers, gradually extending up the hand and arm. Then the fingers became rather forcibly flexed and stiff, but by a voluntary effort he could straighten them. No clonic spasms of the fingers, and wrist and elbow were not bent. The numbness and stiff feeling soon extended to the face, which was drawn to the right side with some force. Speech was again lost. No loss of consciousness. The attack lasted about twenty minutes. Such attacks had occurred every other day, then every day, and finally twice a day up to January 3, and during this time the headache and insomnia were increasing steadily. The character of the attacks was not uniform. Sometimes the spasm would begin in the face, though usually the arm was first affected. Both were involved in every attack, but the spasm and numbness never reached the leg. The hand felt cold during an attack, though warm to the touch. On one occasion he had for four days great difficulty in making himself understood by words. Examination by Dr. Starr showed slight paresis, and slight tactile anæsthesia in right hand, no affection of face or speech. No cardiac symptoms. Though suffering from headache, percussion of skull did not reveal any tender spots. Thrombosis, endarteritis syphilitica, diffuse encephalitis with sclerosis were excluded, and the diagnosis was reached of gumma in the membranes, resting upon the brain surface, giving rise to irritation and consequently to an occasional nervous discharge, but not of sufficient size to cause any destruction. Location of tumor was equally clear; the relative situations of the cortical centres for the arm, face, and for the movements of speech in the lower two-thirds of the anterior central convolution, and in the posterior part of the third frontal convolutions were likened to a reversed L. All these centres were irritated during the attacks, the irritation sometimes beginning in one, sometimes in another. If the tumor pressed upon the lowest posterior part of the second frontal convolution which would lie inside of the L, an irritation radiating from it might reach all three centres equally. The total intermission of the local symptoms might be explained by such a location since no symptoms were known to occur from injury of this part. The fact that numbness in the hand and face uniformly accompanied the attacks of spasm seemed to indicate that

the areas for these parts coincide with the motor areas.

Another point of interest was the distinctly motor character of the aphasia.

The treatment ordered was first inunction of mercury, and second iodide of potash daily in divided doses. He had one attack two days after beginning treatment, but since that time he had had no return of the symptoms. Iodide of potash was still being taken.

#### DISCUSSION ON DR. STARR'S PAPER.

Dr. Seguin had seen several cases whose symptoms resembled those of the case recorded in Dr. Starr's paper. The prognosis of even non-syphilitic cortical lesions with this symptomatology was not absolutely unfavorable. One of the cases to which he referred was that of a Cuban who came to his clinic about nine years ago. He had never had syphilis, yet he described epileptic attacks of the true cortical kind, such as have been obtained by experiments upon animals during the last few years. The hand would become numb, and then the seat of a vibratory sensation; finally contraction would occur in the hand, when the face, and almost simultaneously the leg, would be affected, and he would lose consciousness. According to his friends' account, general convulsions then occurred. He had had quite a number of these seizures; yet examination showed no anaesthesia, no affection of the optic nerve, and, so far as the speaker could recollect, no motor impairment. The patient had received a preparation composed mostly of the bromide of potassium, to which a little of the iodide was added. He improved immediately, and four weeks ago the attacks ceased. Once in a while he has the sensation of wires in the hand, and the hand becomes stiff, but the face is never affected. The case was a beautiful illustration of the localization of a lesion in the centres for the hand, the discharge radiating to those of the face and leg of the same side, then to the opposite side, with loss of consciousness.

The patient had also been the object of the bracelet experiment. He was a powerful man, and had exerted great force, arresting many attacks in this way. The speaker was satisfied that syphilis was absent, while the amount of the iodide was too small to explain a cure upon the ground of a syphilitic affection.

Dr. Starr had been much interested in the case which Dr. Seguin had related. He had recently had a case of unilateral convulsions in his office. The patient was a small boy.

The attack commenced in the eyes and face. The eyes turned to the right, then the head turned to the right; then the arm, then the leg became affected. During the attack the speaker had asked suddenly, "What is your name?" The boy promptly replied, "Arthur," and then relapsed into the convulsion. He supposed that the reply was reflex, as the boy was unconscious at the time, and did not afterward remember the occurrence. He would like the opinion of the members upon the point.

Dr. Dana asked what Dr. Seguin had considered the lesion in his case.

Dr. Seguin had never ventured to surmise beyond the fact that there was a nerve-lesion and that there was no syphilis in the case.

Dr. Starr asked Dr. Seguin whether in localized convulsions numbness were not the rule.

Dr. Seguin replied that it was; but he did not know that the reason was yet sufficiently established, although Von Monakow had associated anaesthesia with lesions of the motor zone.

Dr. Shaw referred to a case seen first four years ago. While at work as a jeweler, the patient fell off his bench in a convulsion. The face and the left arm were convulsed; the leg was not affected. Sometimes only the side of the face was affected. He had seen many of these attacks limited to the side of the face in his office. The patient complained of numbness in the arm and the side of the face, and the speaker felt sure that the tactile sensibility was not as good upon that as upon the other side. The patient denied syphilis. Upon ophthalmoscopic examination the nerves were found pale, and the visual field restricted in its upper part. There was no change until about six months ago, when, without loss of vision, he was found to have choked disk. This had gone on to atrophy, and the man was now blind. There was no paralysis. From the choked disk, of course, the speaker had now diagnosed a tumor, but he referred to the case on account of the anaesthesia and the spasms, and their resemblance to those in Dr. Starr's case.

Dr. Sachs referred to the case of a man who, some years ago, while working upon the Capitol at Albany, had fallen some distance, was found unconscious, but recovered. A few weeks later he developed symptoms which alarmed his friends, and he had now some of the physical, and nearly all of the mental signs of general paresis—the irregular pupils, the facial tremor, the tremor of the tongue, and the deteriorated mentality.

The speaker referred to the case because of the traumatic incident, and because every three or four weeks this man had an attack of numbness, beginning in the fingers and creeping up the right arm to the face. There never were convulsions, but both the patient and his wife, who is a very intelligent person, say that there is paralysis. After three or four hours both the paresis and the numbness disappear, and he has a very severe headache, lasting one or two days. The speaker thought there was a question of chronic meningitis with encephalitis possibly in this case. It was evidently a cortical affair.

Dr. Dana thought that cortical epilepsy might develop like idiopathic epilepsy without an appreciable lesion. He recalled a case, that of a young man who was kicked in the front of the thigh by a horse. Twitching of the leg developed, similar to that of cortical epilepsy. Thrilling and numbness of the arm and face followed. In a year true hemiepileptic attacks, during which he lost consciousness, developed, and upon giving him ether for stretching the nerve he went into the status epilepticus. There was no history of syphilis. Apparently cortical epilepsy was developed just as true idiopathic epilepsy in other cases.

Dr. E. C. Seguin read a paper entitled

#### **A Contribution to the Pathology of the Cerebellum.**

A detailed account of one case was given, and specimens, gross and microscopic, illustrating its pathological anatomy, were shown. Three other cases of cerebellar disease were briefly presented, as card specimens with their anatomical demonstrations. The following is a summary of case 1: Male patient, forty-five years old at time of death; a retired officer of the United States navy. Eighteen years before health illness began with headache (not strictly occipital), and one or more seizures of an epileptiform or apoplectiform character. These were followed by impaired vision and more or less continuous headache (fronto-occipital). Later appeared nystagmus and typical cerebellar titubation; slight slowness of speech. There was no distinct paralysis, ataxia, anæsthesia, vertigo, or mental impairment. During several years, from 1877 to 1883 or 1884, the only symptoms were slight frontal headache, defective vision, partial atrophy of both optic nerves, nystagmus of varying form, slight slowness and indistinctness of speech, increased patellar reflex, and titubation.

In February, 1885, an epileptiform seizure left behind it partial left hemiplegia without contracture and anæsthesia. Death on 22d of April, 1885, preceded by a set of distinctly bulbar symptoms; increased dysarthria, dysphagia, salivation, polyuria, also increasing stupor.

*Lesions.*—Cyst of cerebellum destroying the clauco-ventral part of the middle lobe (not involving the frontal third of the vermis superior), penetrating into the right lateral lobe as far as the nucleus dentatus, not destroying it, and probably exerting only slight pressure upon the floor of the fourth ventricle. There were also found:

1. A small hemorrhagic focus 2 mm. in diameter, in the ventral half of the pons on the right side, in the midst of the pyramidal fasciculi. This explained the left hemiplegia, and from it could be traced a complete descending degeneration of the right pyramidal tract into its subdivisions in the spinal cord.

2. Very extensive arteritis obliterans of the encephalic vessels, causing numerous, mostly symmetrical, foci of softening in the cerebral hemispheres. The only system degeneration which could be traced to the loss of substance in the cerebellum were a moderate reduction in the size of the opposite (left) olive, and partial atrophy of the right rectiform body.

The author called attention to several conclusions to be drawn from a study of these four cases.

1. As to diagnosis. Tumors of the cerebellum produce very variable symptoms, but one symptom, viz., cerebellar titubation, is, as claimed by Nothnagel in 1876 or 1877, pathognomonic of a destructive lesion of the middle lobe of the cerebellum, more especially its caudo-ventral masses. In Dr. Seguin's cases optic neuritis or atrophy had not failed, which was in marked contrast to his experience with tumors of the cerebral hemispheres, which do not usually cause lesion of the optic nerves (1:5 or 1:4). Vomiting was a frequent symptom; occipital headache and rigidity of muscles of the back of the neck were less frequent but very valuable symptoms.

2. As to therapeutics. Three of the patients had obtained repeated relief from serious symptoms; paroxysms of headache, vomiting, and epileptiform attacks, by the use of the iodide of potassium in doses of from thirty to sixty grains three times a day.

3. As to prognosis. Two of the patients did not die of their cerebellar disease—both cysts—but of complications. Case 1 of dif-

fused arteritis obliterans and consequent softening in various parts of the brain, including impaired nutrition of the bulbar nuclei. The other case, No. 2, of an acute tubercular meningitis. Consequently, we may hope in a few cases to cause or to witness an arrest of the cerebellar disease. The disorder in voluntary movements and the already developed lesions of the optic nerves are, of course, irremediable.

#### DISCUSSION ON DR. SEGUIN'S PAPER.

Dr. Bradner spoke by invitation. He had been the attendant in the case of the child to which Dr. Seguin had referred. He had not prescribed the washing out. It had been done by a prominent physician of the place. He had done it a number of times during three weeks, but had then refused, believing that the child had brain disease of some form. He saw the patient first in November. The vomiting was always in the morning. There was no pain connected with it then, although a frontal headache had developed during the last few months. The treatment prescribed by Dr. Seguin had been the iodide of potash, fifteen grains, *t. i. d.*, increasing five grains daily, until one hundred grains were taken at a dose. The course had been interrupted by several attacks of acute gastritis, but the child had had those attacks previously; they did not appear to depend upon the medication. The eyesight has been perfect; the child could detect the smallest point made by a lead-pencil or needle. While using the iodide, his headache had improved, as had some other symptoms, but he retained his old man's gait.

Dr. Seguin remarked that, though seeing well, the child had typical choked disk.

Dr. Bradner added that since seeing Dr. Seguin, he had obtained a history of injury in the case. Two years ago, and just before the commencement of his illness, he had, while trying to skate, fallen, and received a severe blow on the back of his head. One result of this injury had been abiding terror at the sight of a body of water or ice.

Dr. Shaw had shown a child at the American Neurological Association in 1878 on account of a peculiar ataxic gait, like that of locomotor ataxia. The later symptoms had pointed to a tumor of the cerebellum.

Dr. Putnam Jacobi referred to the recent collection of cases by Bernhardt. All cases published previous to 1884 had been collected by Nothnagel. Dr. Seguin's cases tended to confirm Nothnagel's laws. There were many resemblances between the symp-

toms of cerebellar tumor and those of tumor in other parts of the brain. The peculiar violence of the headache and the choked disc found in most cases of cerebellar disease might, she thought, be due to the increased pressure of a tumor confined by the tentorium. This element had not been commented upon, and she would like Dr. Seguin's opinion upon it.

Another point referred to the fact that the laws formulated by Nothnagel recognize the possibility of complete latency of the tumor, no symptoms at all being present when but one lobe of the cerebellum is affected, such symptoms appearing only when the tumor encroaches upon the central lobe. In one of Dr. Seguin's cases the tumor only occupied the lateral lobe. Of course an indirect affection of the central lobe might be present even in such a case.

Dr. Leszinsky referred to a case to which he was called in consultation by Dr. Alexander. The boy had the typical gait of spastic paraplegia; any attempt to stand caused spastic contractures in the limbs, ankle clonus was present, and the knee-jerk was exaggerated. There were no cerebral symptoms; the fundus was normal in both eyes. The father and mother were both alcoholic and unworthy people. Finally the child became unable to walk, but there were still no cerebral signs; no vomiting. Two months before death the fundus was still normal. Later tremor developed, and paralysis of the abductors, and of the fifth and of the third nerves. Total blindness occurred. The nurse, a graduate of Bellevue, was positive that the child could see nothing. It died in a convulsion. Unfortunately, the body was immediately frozen, and the specimen was unfit for sections. The tumor was found occupying one side of the cerebellum. The spinal cord was not fit for examination. There was a well developed meningitis, and the paralysis was accounted for by considerable exudation about the cerebral nerves. One peculiarity has been a subnormal temperature during one stage of the case.

Dr. Starr had had occasion some time ago to make a collection of cortical lesions from American literature. He had at the same time made a collection of cases of cerebellar disease from the same sources. As the data obtained but corroborated Nothnagel's results, he never published them. But Dr. Seguin having remarked upon the value of corroborative evidence, he would briefly refer to them now. From 1860 to 1884 one hundred and sixty cases of cerebellar disease were reported in American literature. In

only forty of these were the symptoms and the autopsies described with sufficient accuracy to warrant conclusions. These forty the speaker had quite thoroughly analyzed. In four there were no symptoms; in one of these there was congenital atrophy of the cerebellum, in two abscess, and in one a large cyst. Of the remaining 36 presenting symptoms there was headache in 36; inco-ordination in 25; vertigo in 20; vomiting in 18; blindness in 14; dim vision in 6; diplopia or strabismus in seven; deafness in 7; facial spasm or paresis in 4; hemiplegia in 9; general paralysis in 4; mental symptoms in 8 (stupid 7, mania 1); convulsions in 7; sexual desire increased in 2. Males, 23; females, 17. Ages: between one and twenty years, 11 cases; between twenty and forty years, 16 cases; between forty and sixty years, 9 cases; over sixty years, 1 case; age not stated in three.

In two of the eleven cases in which inco-ordination did not occur, the lesion probably involved the middle lobe. In cases where inco-ordination occurred various parts of the cerebellum were involved, but the probability was that the middle lobe was affected in the majority. There were only two instances of increased sexual desire. Bernhardt had found but one instance in ninety cases of cerebellar tumor, and Nothnagel but two cases. The speaker thought that it might be thrown out as a symptom of cerebellar disease, and regarded as one of accidental occurrence. The escape from vertigo in Dr. Seguin's case was explained perhaps by the recent discoveries in the anatomy of the course of the acoustic nerve. This nerve served for the sense of hearing and the sense of space. The centre for hearing is in the pons. Edinger finds the centre for equilibrium in the cerebellum, to which acoustic fibres pass by way of the middle peduncle. From this centre the central tract probably passes onward to the superior peduncle. Dr. Seguin says that the superior peduncle escaped in his case. It is therefore natural that vertigo should not have occurred.

The tendency to rotation was an interesting feature in these cases. There was a tendency to fall or turn forward in two cases; the lesion was in both a tumor in the vermis, in the anterior part. There was a tendency to fall to the right in two cases, in one there being a tumor in the left middle peduncle, and in the other an abscess in the same part. There was a tendency to fall to the left in two cases, in one there being an abscess in the right middle peduncle, and in the other a tumor in the left middle peduncle. A pa-

tient of Nothnagel, whom the speaker had seen in Vienna, when getting up in bed, had always a tendency to turn to the right side. Nothnagel considered this due to vertigo. It was only present when the patient was erect. The patient felt as though about to fall to the left side, and hence turned to the right. This case had a tubercle of the left middle peduncle of the cerebellum. Nothnagel considered this symptom only produced by affection of the middle peduncle. In the two cases in the table where the tendency was to turn to the right there was disease of the left middle peduncle, while in the two in which the tendency was to the left, in one the right peduncle and in the other the left peduncle was affected. No rule can, therefore, as yet be laid down as to the cause of this symptom.

Dr. English had had charge of the case which formed the subject of Dr. Seguin's paper, and he congratulated the Society upon the progress which had been recently made in the diagnosis and treatment of cerebellar disease. Early in 1878, Dr. Seguin had written him a letter, accurately diagnosing this case, as seen on autopsy.

Dr. Seguin closed the discussion. He was not surprised to learn of the little boy's fall, as he was a firm believer in the traumatic origin of these conditions. It was very difficult to obtain a history of fall. He could not give an opinion upon the question propounded by Dr. Putnam Jacobi. In regard to ascribing the vertigo to the acoustic nerve, he was not yet certain that the acoustic nerve had cerebellar origin. He thought it would be difficult to trace fibres through the lateral peduncle of the cerebellum, the vermis, and the anterior peduncle.

He said Dr. Starr had probably made a mistake when he referred to Nothnagel connecting rotation with disease of the middle peduncle. Middle vermis he had probably meant to say.

Dr. Starr accepted the correction.

#### How He Released the Finger.

A Western contemporary tells a story illustrating the oft-repeated truth that the surgeon cannot afford to neglect applied mechanics and physics: A young lady had her finger caught in the valve of an air-gun. A physician being called, after careful consideration, decided that the only means of releasing the finger was to amputate it. This being done, the gunsmith arrived, and proceeded to release the amputated finger by boring a hole in the chamber of the gun.

## EDITORIAL DEPARTMENT.

### PERISCOPE.

#### Sudden Death from Nightmare; Some Reflections on the Cause, Treatment, and Prevention.

Dr. Matthew Turner thus writes in the *Alabama Medical and Surgical Journal*:

S. B. C., aged thirty-five years; male; white; married. Native of Alabama. By occupation a farmer.

The subject of this sketch was a young man in full health, of steady habits, used no narcotics or stimulants, and took a great deal of out-door exercise; was seldom "ailing," and, except a mild attack of dysentery and an occasional chill during the summer, was never sick. He was one of a pair or twins, the stouter and more handsome of the two, and was a perfect type of a healthy man in mind and body. He was of nervous temperament.

About the latter part of August, Mr. C. was surveying some land on the river for the purpose of settling a boundary line between him and some neighbors, when he discovered, near the line, a mine of some mineral, supposed to be of immense value, and, like most men under such circumstances, saw visions of fabulous wealth almost within his grasp. Fearing a difficulty about the division, he spent the next day in visiting parties interested, and underwent a great deal of fatigue and a proportionate amount of anxiety. About 8 p. m., he held an interview with the last party concerned, and greatly to his relief found no obstacle in his way to a big fortune—the land was his, and no one was disposed to dispute his title.

Instead of remaining that night, as he expected, from home, he was so much elated at his success that he rode home, ten miles, to communicate his good fortune to his family, who shared in his anxiety.

On reaching home, his wife, not expecting him at that hour, had retired and made no provision for his supper, but told him there were some cold dishes in the closet. Of these he made a hearty meal, having gone without his dinner, and, after talking over the events of the day with his wife, still under great excitement, he retired.

This was about 11:30 p. m., and about thirty-six hours from the time the excitement commenced about the mine. About 5 o'clock the next morning his wife was awak-

ened by his distressed groaning, and, supposing that he was suffering from "nightmare," shook him and aroused him sufficiently to cause him to move himself in bed, and the groaning ceased, and he seemed to drop into a quiet slumber.

Knowing that her husband had been unusually excited and fatigued, his wife quietly got out of bed and adjusted the bed-clothing, with the hope that he might have a quiet nap while she was preparing breakfast. Passing through the room in about a half hour she noticed one foot uncovered, and, in readjusting the covering, perceived that the foot was very cold. Here she discovered her fatal mistake. He was dead, and perhaps breathed his last when she first left him. Had she known his danger, and persevered in her efforts to arouse him at that time, she would in all probability have been successful, and he perhaps would have laughed at the recollections of a dreadful dream, and never have realized how near the portals of eternity he had been.

Now, what are the chief factors in "nightmare?" In somnambulism we have the power of motion unimpaired, but memory and judgment seem entirely suspended. In "nightmare" sensation and memory are active, but the power of motion is lost. Hence we would infer that the kinesodic area of the medulla oblongata is paralyzed, and that the patient dies from asphyxia or heart-failure.

We are all familiar with the sympathy existing between the stomach and the heart, as well as the physical disturbances resulting from indigestion. The child who habitually screams out at night from frightful dreams will often, when put to bed hungry, with only a cracker and a cup of tea, sleep soundly without any terrors, whereas, if allowed to fill the stomach with heavy, indigestible food, he will not only dream, but may have convulsions added to the regular matinee.

We know that fatal syncope has been brought about by taking a heavy draught of cold water, and that the same result may ensue from purely emotional causes.

It is not so much the object of this paper to discuss the causes and the "modus operandi" in these cases, as to call the attention of the profession to the fact that, notwithstanding they are generally regarded as trivial and attributed to an imprudent supper,

etc., they do sometimes become serious, and terminate fatally.

As a preventive measure, the general health should be looked after, and especially indigestion should receive our first attention. Treatment during the paroxysm is simple. A slap, rude shake, or douche of cold water in the face, will usually arouse the consciousness of the patient, and, under the efforts of the will, respiration and circulation are restored.

I would suggest that such subjects should not sleep alone, but always in hearing of some friend or attendant, who will be on the *qui vive* for the first manifestations of an attack, and apply the means of restoration immediately and effectually.

Ammonia, belladonna, digitalis, *et id omne genus*, hypodermically or otherwise, would naturally suggest themselves to the mind; but in the usual course of the attack the physician would seldom be in at the right time for their application, and only in cases where complete restoration is tardy and the organs hesitate in the full resumption of their functions, would they be of any avail.

#### Congenital Stricture of the Urethra in an Infant.

To the Academy of Medicine, in Ireland, Dr. Macan submitted a case of congenital stricture of the orifice of the urethra, hypertrophy of the bladder, and cystic degeneration of the kidneys. The specimen was the first of the kind he had met with, and was taken from a full-grown child in the Rotunda Hospital about a fortnight before. The child was suffering from imperforate anus, and soon died. On examining the abdomen over the pubes, after death, a movable tumor was detected, reaching as far as the umbilicus. From the gristly feeling of it, he first thought it was malignant disease of the bladder. The penis was very much distorted in shape, and oedematous. On opening the tumor, it was found to be the bladder, with thick hypertrophied walls. Fœtal urine, clear and limpid in character, flowed out, and, after the gush, the bladder seemed to fill again, and another gush took place. He searched for some diverticulum in the bladder that might be filled with urine, but found none; but, on cutting down more into the bladder, he found that the fresh flows of urine came through the ureters. It was then apparent that there must be a collection of urine in the kidneys. There was great contraction of the urethral orifice, and great dilatation of the urethra. The right kidney

was blown out into a cyst, and contained a considerable quantity of urine. The left kidney was also disorganized. The intestine ended in a blind sac at the lower portion of the bladder. He thought the primary source of disease was the occlusion of the orifice of the urethra. The accumulation of the liquor amnii during the later stages of pregnancy was a proof that that fluid was, in fact, the secretion from the kidneys of the fœtus. The child in question presented another curious anomaly. On one side of the spinal column there was a depression of the skin, with a cicatrix on the outside, which was proved to be caused by a spina bifida. There was also a deformity in one of the legs.

The President said the specimen was evidence of a well-known pathological law, in accordance with which several different malformations had a tendency to be associated. He did not gather from Dr. Macan whether he held the opinion that liquor amnii was to be looked on as so much diluted urine, or that it was a different fluid, only contaminated by the fœtal urine. The presence of urea in it was not enough to settle the question.

Professor Bennett said Dr. Macan had not mentioned the condition of the urachus. Urinary fistula at the umbilicus was not uncommonly met with without any other deformity; and imperforate anus also occurred independently of the other things seen in the present specimen. The most important point connected with the specimen in a surgical aspect was that of the limb deformity being associated with an indication of damage to the spinal cord. It would be interesting if an examination of the specimen could be made in order to ascertain the extent of the nervous supply to the muscles of the deformed limb, for at the present day the exact nature of the lesions known as "club-foot," and congenital deformity of the hip, were vexed questions. In the present specimen there was club-foot with a distinct lesion, which might involve the nerves that passed into the limb.

Dr. Wheeler expressed regret that the intestine in the present case had not been dissected further up, in order to ascertain where the closure was. Some years ago he brought forward a case of imperforate anus with an opening in the gut at the side of a spina bifida.

Dr. Thornley Stoker said the occurrence of cystoid degeneration of the kidneys in the fœtus, though rare, was not altogether unknown. The degenerate kidney sometimes attained a considerable size, pressed up the

diaphragm, and displaced the liver into the thorax. It was now a matter of considerable interest to surgeons to arrive at a conclusion as to where the bowel could be best looked for in cases of imperforate anus. The most modern plan was to perform laparotomy, or a lumbar operation, and not to attempt any procedure involving the peritoneum.

The President remarked that in some of the islands of the South Pacific nearly all the natives were afflicted with congenital phimosis, and many of them had a preputial orifice no larger than a pin's head.

Dr. Macan, in reply, said he would hardly recommend that a child's abdomen should be opened in a case of imperforate anus. There were cases in which the operation should obviously be a rectal one. In the present specimen, the end of the gut was at the bottom of the bladder. There was no atresia—only a stricture. A very considerable quantity of the liquor amnii must have been urine, unless the child passed a very small amount of water and drank the fluid. Foetal urine seemed to be the only known source of liquor amnii, and the fact that the quantity of urea in that fluid was known to increase towards the end of pregnancy seemed to show that foetal urine was at all events a considerable source of it.

#### Iodide of Potassium in the Treatment of Diphtheria.

Dr. L. Stepp (*Deutsche Med. Wochenschrift*) recommends mercury and iodine in diphtheria. Mercury has been given in various forms and doses in diphtheria and croup, though without any good results, as, owing to its poisonous properties, sufficiently large doses cannot be given to destroy bacteria in the blood. Its action is only efficacious in syphilis. In diphtheria, on the other hand, the incubation-period is from two to five days, and serious symptoms develop rapidly. Iodine seems to be the only suitable medicine; and probably still larger doses are required in diphtheria than in syphilis. These two diseases resemble each other, in that they both have a tendency to encroach on the bucco-pharyngeal mucous membrane, and thereby affect the neighboring glands. Iodide of potassium is decomposed in the organism, and iodine remains in the blood and other liquid elements, and in the glands, where it amalgamates with albuminoid molecules, and possibly with bacteria; in any case, it sterilizes media in which bacteria develop. Dr. Stepp mentions one case

of diphtheria out of many which he has treated with iodide of potassium. The patient, a girl aged 7, who had been ill for three days, had a very thick false membrane in the pharynx, the glands of the neck were involved, the pulse was weak, and the temperature high. Three grammes of iodide of potassium were given in 120 grammes of water. At the end of a week, the child was completely cured. A boy, aged 7, in whom diphtheria had come on three days previously, was treated in the same way. A teaspoonful of the solution was given every hour; two days after the treatment was begun, the temperature was lower, and the general condition better, though there was no apparent change in the state of the pharynx. Twenty-four hours later, the child's condition became alarming; there was cyanosis of the cheeks and lips, the pulse was 140 to 160, and the little patient fell into a condition of complete apathy. No medicine had been given for fifteen hours, as the smell of the iodine had caused nausea. The following mixture was then ordered:

R. Iodide of potassium,	100 grammes.
Water,	20 grammes.
Syrup of orange peel,	20 grammes.

A teaspoonful every hour night and day. Tokay wine was also ordered at intervals.

On the fourth day of the new treatment, the patient's condition was greatly improved, and the pulse was stronger. A teaspoonful of the solution of 5 grammes of iodide of potassium in 120 grammes of water was given. On the fifth day, the temperature was lower, but the swelling of the neck and the false membrane in the pharynx remained unchanged. Eight grammes of iodide in 120 grammes of water were then given in doses of a teaspoonful every hour; on the following day the dose was increased to 10 grammes of iodide. On the seventh day, the false membrane became detached, the cough was looser, and there was less hoarseness, whilst the infiltration of the neck had disappeared. The pulse was 132, the temperature 38.3° C., and the general condition satisfactory. On the eighth day, the temperature rose to 39° C. towards evening, but fell again on the ninth day; the false membranes had disappeared, and the cough was not so hard, though the voice remained rather hoarse. Complete convalescence was established on the tenth day. In the course of one week the child had taken 50 grammes of iodide of potassium. There have been no subsequent symptoms, either as regards the digestive organs or the nervous system.

### The Pathological Anatomy of Chorea.

Fatal cases of chorea are not very common, so that every carefully conducted post-mortem examination is of value in aiding to discover the morbid conditions present, and to decipher the pathology of the disease. The opinion is becoming more and more general that chorea is not an entity as a disease; that there are, indeed, several forms, varying in their etiology, to some extent in their symptoms, and in their sequelae. In a case of chorea minor, which ended fatally by an attack of apyretic pneumonia, Nauwerck made a careful examination of the nervous system, both central and peripheral. He found that the peripheral nerves were normal, but that in the central nervous system there were many changes, all of which were microscopic. He divides these changes into three classes. In the first he includes patches, here and there, of infiltration of the perivascular sheaths by round cells, extending sometimes into the surrounding tissues. This infiltration was most marked in the medulla and pons; there was none to be observed in the spinal cord, the cerebellum, the basal ganglia, or the cortex of the brain. In the second class of changes, Nauwerck describes points of hemorrhage, one to two millimetres long, situated in the cerebral peduncles, the inner capsules, and in the medulla and pons. No capillary emboli were found. In the third class, changes in the nerve-fibres are described; these consisted chiefly in a degeneration which was most marked in the white substance of the cervical spinal cord, gradually diminishing downwards to the lumbar region. Microscopically, the axis-cylinders of the fibres were seen irregularly swollen, in the condition which is known as "hypertrophy;" they stained badly with neutral carmine, and osmic acid showed fatty granules in their interior. In some fibres, the place of the axis-cylinder was wholly occupied by fat-globules. The degeneration of the fibres did not occupy any particular tract of the cord, but was scattered irregularly. Nauwerck considers that the perivascular infiltration of round cells is to be taken as a sign of inflammation; and that it is probable that the degeneration of the nerve-fibres would explain the incoördination of movement in the case recorded by him. A strict search was made for micro-organisms, but none were found in any part of the nervous system. He thinks that there is a group of cases of cholera which may be called infectious, the poison being exclusively localized in the central nervous system.

### Uterine Tents and their Effectual Disinfection.

Dr. Dirner, of Buda-Pesth, has recently written in the *Centralblatt für Gynäkologie* on the effectual disinfection of tents used for gynaecological purposes. He observes how, after the greatest precautions, serious pelvic inflammation may follow the introduction of sponge or laminaria tents. This accident is clearly due, not to the mere ulceration of the dilated structures, but to the introduction of septic material through the wounded mucous surface. The preparation of tents by soaking or coating in antiseptic media is insufficient. Septic matter may be introduced with the aseptic tent; surgeons handle and throw about samples at the shops, nor is the process of manufacture always properly superintended. Fritsch's method of coating tents with wax requires warm water to be at hand when the wax has to be melted, and that water may be septic. Dr. Dirner has detected cracks in the wax, allowing the admission of dust. The most carefully prepared dry tents can convey septic germs on their surfaces. For a year Dr. Dirner has employed in Professor Tauffer's wards a special system of disinfecting laminaria tents. He immerses them in a 1 per cent. solution of corrosive sublimate in absolute alcohol contained in a wide-mouthed bottle. When required, a tent is taken straight out of the solution and passed into the canal of the cervix, the patient being previously placed in the semi-prone position, and the vagina disinfected. He takes care to inspect hollow stems before introduction, and should any crystals of sublimate be detected in the channel of a stem, it is dissolved with pure water. The results of this practice have been admirable, and he has seen no bad effects follow the introduction of the disinfected tents; provided that absolute alcohol be employed, the expansive power of the laminaria is in no way damaged.

### Koeberle on the Treatment of Uterine Cancer by Hysterectomy.

Professor Koeberlé, of Strasburg, has recently given his views on this subject in the *Nouvelles Archives d'Obstétrique et de Gynécologie*, and they have been ably summarized in the *American Journal of Obstetrics*. He points out that primary cancer of the body of the uterus is very rare. When it occurs, the cervix is not affected for a long time. Cancer of the cervix generally begins near the os externum, and spread thence over the tissues of the cervix, involving the vagina

and adjoining organs, before it passes beyond the level of the os. As long as the disease has not extended to the broad ligaments, or to the lymphatic glands which communicate with the uterine lymphatics, the body of the uterus will be free from malignant disease. Under these circumstances it is not necessary to remove it. When the body of the uterus is the seat of primary cancer, the cervix being sound, it is useless to remove it. Thus, total extirpation of the uterus, whether by abdominal section or through the vagina, is more dangerous and difficult than removal of either the cervix or the body alone. Hence that operation should be reserved for cases in which partial amputation will not suffice for the complete removal of the disease. Supravaginal amputation of the body by abdominal section is applicable to cases of primary cancer of the body not involving the cervix: supravaginal amputation of the cervix through the vagina should be reserved for cases where the cervix to the level of the os internum is alone diseased. Total extirpation, or hysterectomy, is allowable only in cases where that operation is rendered relatively simple and safe, by the existence of complete prolapse of the uterus. There can be little doubt that all these operations are complicated and dangerous, and that in any one case it is always extremely difficult to make sure of the extent of the disease. Early amputation of the vaginal part of the cervix, by means of the galvanocautery, is likely to become a more popular method of treating cervical cancer in this country. Supravaginal amputation of the body of the uterus, the stump being secured by Koeberlé's *serre-nœud*, has proved very satisfactory in cases of fibroid, and appears to be the best manner of treating cancer confined to the body.

#### Case of Displacement of the Hip after Fever.

Mr. T. Pickering Pick exhibited to the Medical Society of London a boy with dislocation of the heads of both thigh-bones, the result of softening and yielding of the capsular ligaments. The right thigh-bone was dislocated forwards on to the front of the pelvis, and the left upwards and backwards on to the dorsum of the ilium. Twelve months before the boy had suffered from acute necrosis of the right tibia, probably followed by pyæmic synovitis of both hip-joints, with rapid effusion into the articulations and softening of the capsule. Owing to the position which the boy assumed, the

heads of the thigh-bones pressed on this softened structure, which yielded and allowed the heads of the bones to slip out of the acetabular cavities. When admitted into hospital the right thigh was everted, rotated outwards, and flexed on the pelvis, and the left thigh was adducted and rotated inwards and also flexed, and the limbs fixed in this position. Mr. Pick performed osteotomy on both sides, dividing the neck of the femur on the right side and the shaft of the bone just below the trochanters on the left. This had the effect of bringing the limbs into a much better position, though some slight amount of inward rotation and adduction still remained on the left side. The boy could, however, walk with a certain amount of support.

Mr. Adams asked whether, in cases of dislocation after fever the capsular ligament was ruptured or distended.

Mr. Morgan related a similar case in a lad in which he had cut down and examined the condition of the parts. He found the capsular ligament distended and tense over the head of the femur; on cutting through it the latter was found perfectly healthy, but the acetabulum was almost filled with granulation tissue.

#### Inoculation of Tuberculosis by Circumcision.

In the *Berlin. klin. Wochensch.*, No. 35, 1886, Dr. A. Eisenberg reports a case of the inoculation of tuberculosis in a child during the operation of circumcision. It is well known that in the lower classes among the Jews, circumcision is followed by suction of the wound, either by the operator or by some other person. Syphilis has been communicated in this way in many cases, and Dr. Eisenberg's observation shows that the same may be the case with tuberculosis. The parasites at first proliferate on the surface of the wound, then reach the lymphatic glands, from which they spread throughout the organism, giving rise to lesions which sooner or later cause death. In the case referred to, the inguinal glands become swollen, and abscesses formed. Tubercle-bacilli were found in the glands, but no *post-mortem* examination was allowed. The child was born of healthy parents. Lindmann observed two similar cases in 1873, and Lehman reported ten others in 1879. In every instance, suction was performed by a phthisical operator. In all these cases the glands of the groin became inflamed within three weeks after the operation. Later on, scrofulous swellings were seen in the lower limbs, in which large

abscesses formed. In other cases, the children died of tubercular meningitis. In one case a phagedænic ulcer destroyed the glans penis. Three of the children are still alive, and have a very characteristic scrofulous aspect. With regard to these cases, however, no positive statement can be made, as the bacillus of tubercle had not been discovered at the date of the supposed inoculation, and consequently no microscopic examination was made.

## REVIEWS AND BOOK NOTICES.

### NOTES ON CURRENT MEDICAL LITERATURE.

—Dr. L. H. Luce publishes through D. C. Heath & Co., Boston, a partial, one-sided, prejudiced pamphlet, entitled "A Synopsis of the Nature and Effects of Alcohol and Narcotics." (8vo., pp. 28.)

—In the antiseptic treatment of summer diarrhoea, Dr. L. E. Holt regards naphthalin and the salts of salicylic acid as the most valuable antiseptics for the intestinal tract (reprint from the *N. Y. Med. Journal*).

—A valuable study is that by Dr. John J. Reese, of Philadelphia, on "Live Birth in its Medico-Legal Relations." It is printed by the Medical Jurisprudence Society of Philadelphia.

—A number of cases of poisoning from the eating of dried beef are reported in an article by Dr. R. Harvey Reed, of Mansfield, Ohio. They were apparently brought about by the presence of ptomaines.

—The subject of follicular amygdalitis is treated by Dr. A. Jacobi, of New York, in a reprint before us. It is written with his customary thoroughness of study.

—The local causes of vesical irritation in women are emphasized in a reprint by Dr. Virgil O. Hardon, of Atlanta, Ga. He very justly observes: "Many a patient has been dosed with buchu, cubebs, nitre, citrate of potash, and the like, for a supposed cystitis, when a simple examination would have revealed a fissure of the anus, a stricture of the urethra, or a displacement of the womb, as the cause of all the trouble. If the possibility of such an origin of frequent micturition be borne in mind, one will not be apt to be led into error, for the differential diagnosis will be easy."

### BOOK NOTICES.

**Leçons sur les Maladies du Systeme Nerveux.** Par J. M. Charcot, Professeur, etc., Paris. A. Delahaye et Cie, 1887.

The name of the distinguished Professor at the Salpetriere is familiar to medical readers the world over, and the admirable lectures which are contained in this work are well calculated to increase his renown. They are well reported by different hands, and cover a great variety of topics. To illustrate their scope, we quote the titles of some of them:

"On Muscular Atrophy following Certain Articular Lesions."

"The Hysteria of Young Boys."

"Special Affection following Injury of the Sciatic Nerve."

"The Different Forms of Aphasia."

"Rhythmic Chorea and Choreiform Movements."

"The Relations of Spiritualism to Hysteria."

"Six Cases of Hysteria in Adult Males."

"Hysterical Deafness in Men."

"On the Muscular Sense and Voluntary Motion."

"On Muscular Atrophy in Hysterical Palsies."

It will be seen that such subjects as these, treated by the master alienist of the age, are eminently attractive reading. The work is illustrated by numerous wood-cuts, and is neatly printed.

**A Compend of Obstetrics.** By Henry G. Landis, A. M., M. D., etc. Third edition. Pp. 113. Illustrated. P. Blakiston, Son & Co., 1884.

The "Quiz-Compend," issued by the Blakistons, have proved of much utility to medical students, and are generally well prepared. The one before us by Dr. Landis, on Obstetrics, is an excellent summary, arranged in the form of question and answer, and fairly merits its popularity.

**A Compend of Electricity and its Medical and Surgical Uses.** By C. F. Mason, M. D., with an Introduction by C. H. May, M. D. Pp. 108. Illustrated. P. Blakiston, Son & Co., Philadelphia, 1887. Price, \$1.00.

The author has aimed to present in this small volume a clear, short, and comprehensive view of medical electricity, suitable to the needs of the medical student. He may be considered to have accomplished his task in a satisfactory manner.

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## THE QUARTERLY COMPENDIUM OF MEDICAL SCIENCE.

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### POLYURIA AND DISEASES OF THE BRAIN.

In traumatic affections of the skull, the prolonged pressure of polyuria has always been looked upon as a symptom indicating the existence of some morbid condition of the brain. To determine, if possible, the exact seat of the lesion, Dr. O. Kahler (*Prager Ztsch. f. Heilkunde* vii., p. 106,) has made a series of studies.

From 25 cases of polyuria after injuries reported in literature, and from 21 of the same where the symptom accompanied diseases of the encephalon not caused by a trauma, and from two cases (one of each kind) of his own, he draws the conclusion that polyuria always indicates some affection of the parts of the brain situated in or near the posterior lobe, the cerebellum, pons, and medulla oblongata, but that the material on hand does not permit a more exact localization.

He then experimented on numerous rabbits, and he found the same, viz., that a change in the urinary secretion results from lesions of the medulla oblongata, the pons and the cerebellum, but that the vermiform appendix has no special connection with a morbid alteration in the functions of the kidneys. Polyuria was caused most frequently when the lateral parts of the posterior end of the pons and the adjoining portions of the medulla oblongata were injured. It is a symptom showing an irritation of the cerebral parts concerned, but it is never only a functional disturbance. Polyuria, especially if not permanent, might, therefore, indicate a passing hyperemia, or an otherwise transiently irritated state of the portions of brain-tissue mentioned, but if continuous and not amenable to treatment, the same symptom would be an evidence of some organic lesion of the same cerebral parts. This theory is confirmed by the empirical observation, that ergot is the only remedy which has thus far resulted in a cure of polyuria. This drug was first tried in a case of that kind by Prof. Da Costa, where it was successful. Since then many similar observations have been recorded in medical literature. Ergot, as well known, causes a contraction of the capillaries and, therefore, a diminished blood supply mainly in regions specially rich in capillaries, as the brain and spinal cord. A transient hyperemia will thus be relieved, and the polyuria, when due to the latter, disappear under the influence of ergot. But when the prolonged administration of this remedy does not diminish the flow of urine, the suspicion is warranted of an organic change in the parts mentioned of the brain.

being responsible for the polyuria. In such cases the symptom is of grave import, and usually predicts the fatal issue of the case. The fact that polyuria, if of long duration, occasionally ends in diabetes, sugar being added to the augmented urine, also is explained by the statements above made, for the morbid seat of polyuria in these cases is situated near to the floor of the fourth ventricle, and the morbid process might well extend to these parts, irritation of which in animals has always been followed by the appearance of sugar in the urine.

#### THE EFFECTS OF SEWER POISON.

The eminent Dr. W. S. Playfair, of London, recently delivered an address on defective sanitary household arrangements as a cause of puerperal disease.

It was devoted especially to the poisoning of lying-in women by sewer-gas. He justly states that this source of puerperal disease has received scarcely any attention at all, and is hardly alluded to in the text-books. But he brought forward a number of cases which can leave no doubt but that it is a frequent and serious cause of septic poisoning.

He also made the important suggestion that these poisons may be absorbed and remain latent in the system, and only show their malific influence after delivery. Instances of this kind were adduced, which must challenge the careful attention of all obstetricians.

The common use of stationary wash-stands, of bath-rooms and water closets in the centre of the house, of a congeries of pipes connected with a foul well or common sewer—all these so-called "modern conveniences" are a standing menace to the health and life of women in parturition.

Doubtless the health of households would be better if all such were banished from the dwelling, and that, like our ancestors, we removed such necessities from our residences to the grounds adjacent.

#### NOTES AND COMMENTS.

##### Catalepsy in a Mother and Child.

Dr. Van Schoot discusses in a Dutch medical journal a case of convulsive seizures of a peculiar kind in a woman in the seventh month of pregnancy. When he first saw her she was motionless, her face being cyanotic, but her temperature, respiration,

and pulse normal. She was quite unconscious, and the slightly dilated pupils did not react to light. The arms were flexed at right angles, requiring some force to move the forearms. By means of chloroform all the contracted muscles relaxed, and some hours' sleep was obtained. Afterwards she remembered nothing of the fit, but she stated that all movements of the fetus seemed to have ceased, and no heart sounds could be detected. These attacks were repeated frequently for a fortnight, the urine being quite normal all the time. Large doses of bromide were given without effect, but some amelioration was produced by sulphate of atropine. Latterly the attacks were associated with considerable movements of the abdominal muscles. Some temporary benefit was obtained by subcutaneous injections of pilocarpine. At the conclusion of a fortnight from the first attack labor came on, a female child being born alive, which, however, died in a week's time, after repeated convulsions similar to those affecting the mother. The mother had no attack till the fifth day (the same day that the child's first attack occurred). After this there was only one more attack two days later, complete recovery ultimately taking place. The author, referring to the diagnosis, is disposed to exclude eclampsia, because, although there were clonic contractions of the abdominal muscles, the main spasm—indeed, at first the only kind of spasm—was tonic. The entire absence of albuminuria, too, tends to exclude eclampsia. Again, epilepsy may be excluded, as after the tonic no clonic spasms occurred, and as the limbs remained fixed in a certain position for one or two hours. He therefore considers that the attacks were of a cataleptic nature, both in the mother and child.

##### The Use and Abuse of Pessaries.

Dr. Fitzgerald read a paper on the use and abuse of pessaries before an English medical society, in which he said it was a matter of common sense that when a body, be it uterus, humerus, or intestine, was dislocated, it should be restored to its place as soon as possible. The case was, of course, different when an organ, such as the uterus, was bound down by inflammatory adhesions, and grave consequences had followed forcible attempts at replacement, and the routine use of pessaries in such cases. The normal position of the uterus was more or less one of anteversion; he was disposed to consider congenital retroflexion, or even retroversion,

extremely rare. In cases of acute flexion, pessaries were not, as a rule, of much service. The causes which tended to push the uterus backward in women were very numerous. He considered it a mistake to keep women so long on their back after child-birth, as the heavy uterus was thereby allowed constantly to gravitate back into the hollow of the sacrum. The patient should be advised to sit up occasionally, and to lie alternately on her side and chest. He differed from those who regarded stenosis of the cervix as of no importance in producing dysmenorrhœa, for although this condition might not matter as long as the flow was fluid, yet it produced almost complete stoppage as soon as clots were formed, and uterine spasm or colic was the consequence. Dr. Fitzgerald then related several cases illustrating the relief often given by the replacement of a dislocated uterus.

#### Artificial Alimentation.

Dr. D. G. Hays, in an article on this subject in the *N. Y. Med. Jour.*, arrives at the following conclusions:

1. Many pathological processes arise from an improper dietary, and many others may be controlled by a proper dietary. There is a celebrated proposition by M. Broussais: "He who does not know how to manage the stomach will never know how to treat disease."

2. Mal-assimilation is a cause of disease. Peptones in the general circulation being poisons, when from any cause metabolism is interrupted, the system is prone to take on pathological conditions.

3. In pyrexia: *a.* The digestive juices, being less in quantity and impaired in quality, should be re-enforced by the artificial digestive ferments. *b.* The stomach is feeble in a muscular sense, and incapable of dealing with large quantities. Hence concentrated or predigested foods should be furnished it. *c.* The process is one of tissue destruction (histolytic). Hence we must furnish the materials for repair (histolysis). How and when to furnish these is still a disputed question. *d.* Feeding is not the cause of pyrexia, nor starvation its cure. Though the former augments it and the latter decreases it, we gain most by keeping up nutrition. *e.* The excess of urea excreted is not proof of nitrogenous waste in the blood.

#### An Experimental Research upon Rabies.

At the stated meeting of the Philadelphia Academy of Surgery, February 7, 1887, Dr. H. C. Ernst, of Boston, Mass., read an in-

teresting paper on this subject, which embraced the following conclusions:

1. That there exists in the cords and brains of animals inoculated in Pasteur's laboratory a *specific virus* capable of the production of similar symptoms through a long series of animals.

2. That these symptoms are produced with absolute certainty when the method of inoculation is by trephining the skull and injection under the dura mater; with less certainty when the inoculation is by subcutaneous injection.

3. That the strength of this virus is lessened when the cords containing it are removed from the animals, and placed in a dry atmosphere at an even temperature.

4. That the symptoms produced by the inoculation of this virus only appear at a certain period of incubation, distinctly shorter when the inoculation has been done by trephining than when done by subcutaneous injection.

5. That injections of the virus modified in strength by drying, and in the manner prescribed by Pasteur, exert a very marked protective influence against an inoculation with virus of full strength.

6. That a very moderate degree of heat destroys the power of the virus entirely, whilst prolonged freezing does not injure it.

#### Right Hemianæsthesia of Cerebral Origin: Trephining.

The *Brit. Med. Jour.* of March 5 says:

A case of much interest is at present under the care of Professor Grainger Stewart in the Edinburgh Royal Infirmary. The patient, an elderly man, received an injury to the back of his head on the 1st of January last. The accident was not immediately followed by serious symptoms. Since then, however, he has complained of gradually advancing anæsthesia of the right side, especially of the arm and leg. On admission, the anæsthesia was precisely determined, and he was found to be suffering from double optic neuritis. During the last few days, signs of an advancing condition of torpor manifested themselves. Accompanying this, there was evidence of motor paralysis in the anæsthetic limbs. The temperature was subnormal. Professor Grainger Stewart concluded that the symptoms were due to pressure, either cortical or the result of cerebral abscess; and, as the symptoms were progressive, he requested Professor Annandale to operate. Accordingly, on February 22, Mr. Annandale trephined the frontal bone, immediately

in front of the left anterior parietal angle. About two ounces of a dark-colored, grumous fluid escaped, and it was found that the finger could be passed freely beneath the dura mater into a large cavity, which separated the surface of the brain from the dural covering. The surface of the brain appeared healthy. The cavity was gently syringed, and the patient, so far, is doing well.

#### Death from Whitlow.

Dr. R. H. A. Hunter thus writes to the *Brit. Med. Jour.*:

W. P., aged 7, was brought to my consulting-room on the evening of October 6, 1886, suffering from a small whitlow on the ring-finger of his left hand. On examination, I found the whole left hand and forearm œdematous, and inflamed in patches. The temperature was 101°, the pulse 120, and the tongue was thickly coated. Having made an incision on either side of the distal phalanx down to the bone, and ordered linseed poultices with frequent warm water bathing, I prescribed a calomel and compound jalap powder, with a saline mixture containing small doses of aconite. On the 9th, the temperature and pulse became normal. The patient was then put upon quinine, steel, and port wine. On the 10th, the œdema of the hand and arm had disappeared, and the finger looked comparatively healthy. On the 11th, retching and vomiting set in, without any increase of either pulse or temperature, and continued unabated in spite of the use of such remedies as bismuth, cerium, hydrocyanic acid, opium, etc., until the morning of the 12th, when death took place from exhaustion, although beef-tea and port wine were frequently administered by enema. From first to last there was neither swelling nor tenderness of any part of the abdomen, and head-symptoms were entirely absent, the child being conscious to the last.

#### Arm and Shoulder Presentation; "Spontaneous Expulsion" (Douglas).

Dr. Penruddocke (*Brit. Med. Jour.*) was called, on December 12th, at 1 p. m., to see a Mrs. W., who was in labor with her second child. On arrival, he found the right arm of the foetus already in the world, with the right shoulder firmly fixed against the arch of the pubes, and was informed by the nurse that it had been in this position for the last two hours, the liquor amnii having been discharged at 10 a. m. The pains had been regular and severe, but were becoming

weaker; he therefore decided to turn, but found great difficulty in introducing his hand, the foetus being so firmly fixed and low in the pelvis. He had nearly succeeded in reaching a foot, when the uterus commenced acting very forcibly, compelling him to withdraw his hand.

The pains continued, and the shoulder still remaining fixed beneath the pubes; the spine and body of the foetus became flexed upon itself; the nates descended and swept over the perineum, being followed by the lower extremities. The other arm now came down, and the head was delivered as in cases of breech presentation. The child, a girl, appeared to have been dead some hours; it was quite mature, but thin, and the funis was twisted twice round its neck. The placenta followed immediately, and when he left the house, his patient was feeling very comfortable.

#### Inherited Phthisis.

Professor Firket (*Revue de Méd.*, January, 1887), writing upon the subject of heredity in tuberculosis, points out certain difficulties in the acceptance of the doctrine of direct transmission from parent to offspring. Such transmission may conceivably take place before conception, the tubercular bacilli being associated with the sperm or germ—a purely hypothetical idea—or through the medium of the placenta, and therefore solely by the maternal blood. He contends that there is not such positive proof of infection of the maternal blood, and thereby of transmission of disease to the foetus in the case of tuberculosis, as there is in anthrax, or syphilis, or variola and other affections. Moreover, he shows that in ordinary phthisis fully one-half of the cases do not exhibit, in the presence of remote secondary lesions, evidence of blood infection. It is for the most part a local disease of the lung, and such secondary lesions as do occur may be explained in many cases apart from general blood contamination. How different, it may be said, from the old notion of phthisis! But the fact of the lung being the primary seat of tubercular disease in inherited cases (says the *Lancet*) is almost conclusive against the congenital theory; for if the foetus were infected through the blood, the chances are that the lungs would not suffer more than any other organ.

#### The Cure of Boils by Injections.

Dr. Bidder described, at a recent meeting of the Berlin Medical Society, a new method

of treating furuncles by parenchymatous injections of carbolic acid. If the boil is a small one, he gives one injection of a few drops of a solution of carbolic acid (2 per cent.); if it is of medium size, two injections are given, the half or the whole of a Pravaz-syringeful of the solution being used on each occasion. In the case of large furuncles, for example, half the size of a man's hand, Dr. Bidder injects at four different spots the contents of four Pravaz syringes half or wholly filled with a solution of 2 per cent. of carbolic acid. These injections are given only once. This treatment is strikingly successful. There is some smarting at the seat of injection at first, but the pain soon disappears, and the next day there is a marked improvement in the patient's condition. The inflammatory swelling subsides very quickly, and in eight or ten days even the largest furuncle is dispersed. By this plan no unsightly scars are left, a circumstance which in many cases is of considerable importance. The success of the treatment is probably to be accounted for by the fact that either the microbes which cause the disease are killed, or the medium in which they flourish is destroyed.

#### Penetrating Abdominal Wound.

At a meeting of the Lucerne Medical Society, Drs. Steigers (senior and junior) showed a man who, in a brawl, had been stabbed in the hepatic region with a jack-knife. From the wound, which measured eight centimetres in length, there protruded four intestinal loops about eight or ten feet long, and perforated in seven places. Having sewn up the holes, the authors enlarged the abdominal wound, and returned the bowels through it, closing it afterwards with an *étage* suture. The operation lasted two and a half hours, and was performed under the internal administration of tincture of opium (140 minims), chloroform being contra-indicated by the extreme prostration of the patient. The temperature never rose above 38.2° C. For the first four days the patient was allowed neither food nor drink; on the fifth day, 150 grammes of water and the yolk of two eggs were given. The bowels were opened with an enema on the eighth day, and, on the tenth day the patient was allowed to get up.

#### Physical and Chemical Properties of Antipyrin.

Professor V. A. Tikhomiroff, of Moscow, says (*Proceedings of the Moscow Physico-Medical Society*, Nos. 5 and 6, 1886,) that a

pure preparation of antipyrin is rapidly and completely dissolved in water, the solution having a neutral reaction. The most characteristic reaction of the drug is that a very weak, slightly yellowish, solution of perchloride of iron becomes dark reddish-brown in color when a small quantity of antipyrin is added to it. On the subsequent addition of a drop of sulphuric acid, the mixture becomes completely discolored. Another characteristic property of the drug is that, on mixing a watery solution of it with an excess of nitrous acid (or, rather, with a mixture of  $\text{KNO}_3$  and  $\text{HCl}$ ), a green precipitate, bearing the name of "iso-nitroso-antipyrin," appears, and forms spherical masses, which, as seen under the microscope, closely resemble colonies of yeast-fungi (*saccharo-myceterevisiae*). This appearance is produced by the aggregation of extremely minute crystals, having a double refraction. The precipitate is soluble in caustic alkalies and ammonia, the solution being of a greenish-yellow color.

#### Extirpation of the Spleen.

At the recent congress of Russian medical practitioners, Dr. A. G. Podrez, privat-docent in Kharkoff, read a paper on extirpation of spleen, including the notes of a case in which he himself had recently performed this operation. The patient was a woman with ague-cake, associated with ascites and extreme cachexia. The operation was performed on the 22d of November last; the patient subsequently went on well, being able to get up on December 10. The weight increased and the ascites disappeared. On the 16th, however, she had a rigor, and the urine contained a large quantity of albumen and hyaline casts. Death occurred on the 27th, and was due, as shown by the necropsy, to diffuse parenchymatous nephritis. The total number of cases of extirpation of the spleen collected by Dr. Podrez (including his own) is forty-two. Of these one was performed in 1549 by Saccharelli, and one in 1711. The rest all belong to the present century. If his own case is reckoned as a recovery, the mortality is 73 per cent.; if otherwise, the mortality is 76.

#### Endoscopy of the Male Bladder.

Dr. Nitze recently exhibited his electric apparatus for the examination of the male bladder to the members of the Berlin Medical Society. This endoscope is not altogether new, but it has lately been so much improved that a short account of it may not be out of

place. Endoscopic exploration is often useful in leading to the discovery of small stones or tumors, and in revealing the cause of the bleeding in certain obscure cases of hæmaturia. Sir H. Thompson's perineal incision does not always allow of a satisfactory examination being made with the finger, while Guyon's "high operation" is dangerous, as compared with the mere introduction of a tube by the natural passage. Dr. von Bergmann related a case of vesical tumor on which he had operated after examination with Nitze's "cystoscope," and dwelt on the advantage, in a procedure of such gravity as opening the bladder, of being perfectly acquainted with the exact site and size of the tumor.

#### Tracheotomy in Diphtheria.

After discussing the time at which this operation should be resorted to, in the *Brit. Med. Jour.*, March 5, Dr. W. Watson Cheyne thus concludes: "It will be evident that the object of this paper is not to recommend the application of any particular antiseptic substance in this disease, but to raise the question of the indications for performing tracheotomy in diphtheria. And I believe more lives will be saved by opening the trachea early, as soon as the larynx is evidently attacked, and by attempting to prevent the spread of the membrane downwards than by delaying the operation till symptoms of obstruction are marked. The probable advantages, I think, more than counterbalance the possible dangers, for, apart from the advantages generally admitted to attend early tracheotomy, there is the further advantage that there is a possibility of arresting the spread of the disease, and also of applying medicaments to the larynx."

#### Multiple Neuritis after Diphtheria.

Dr. Campbell Pope presents notes of a case under this title in the *Brit. Med. Jour.* A young man was admitted into the Queen's Hospital, Birmingham, three months ago, with almost complete paralysis, which had commenced in the legs, and later on had affected the forearms. Ten weeks previously he had had a sore throat. His sister, living in the same house died of diphtheria, and his larynx was anæsthetic on admission. There were well marked dropping of the hands and feet, emaciation, marked tenderness in the calf muscles and along the nerve trunks. He suffered from shooting pains before admission. A prick of a pin caused two sensations, touch being first perceived,

and pain after. The reaction of degeneration was present in the extensor muscles of the legs and forearms. He was now improving gradually, taking 40 minims of the liquor strychniæ three times daily, and being galvanized and rubbed.

#### The Curability of Cancer by Operation.

In a paper on this subject published in the *Medical Record*, Dr. George F. Shrady arrives at the following conclusions:

1. Cancer is essentially a local disease, and can be cured by operation in spite of recurrence.
2. Operation, when it does not cure, prolongs life and diminishes the total amount of suffering.
3. Operations should be repeated as often as there is any chance of entirely removing recurrent growths.
4. The earlier and the more thoroughly the operation is performed the better.
5. The disease, when it recurs, is generally of a milder type than that of the original growth, less painful and less exhausting.
6. Antiseptic surgery makes more radical operations possible, with better ultimate results than formerly obtained.

#### Antiseptic Collodion.

The *Journal de Médecine* of December 26 contains an account of a new kind of "collodion," which is antiseptic and promotes cicatrization. It does not cause inflammation, and may be substituted for collodion made from gun-cotton, in the treatment of wounds and bruises. Like traumaticine, it is efficacious in relieving neuralgic pains, and acute or chronic rheumatism. The affected parts should be sponged with it every twenty-four hours, and in serious cases every six hours. If strips of linen or silk be soaked in this collodion, an excellent sticking plaster is obtained, which quite equals English court-plaster. The following is the formula: Mastic in globules, 3 grammes; balsam of Peru, 1 gramme; narcotine, 1 gramme. Each ingredient should be ground separately, and 5 grammes of chloroform added thereto.

#### Gunshot Wound of Vertebra.

Before an English Medical Society, Mr. J. T. J. Morrison showed a man, aged 25, who nine weeks ago shot himself in the mouth, discharging a No. 7 conical Eley bullet from an ordinary revolver. On admission there was some shock, but no loss

of consciousness. The tongue and palate were blackened with powder; the soft palate presented a round perforation, through which the tip of the finger could feel an opening in the bony wall of the pharynx. A probe passed through this aperture, traversed a canal in the bone about an inch in length, and impinged on a hard substance at the bottom. There were no signs of spinal concussion or hemorrhage. No attempt was made to extract the bullet. The patient was now in excellent health, the hole in the vertebral column having closed, and its place being indicated only by a slight elevation.

#### An Example of Abortive Treatment.

Dr. C. R. Illingsworth thus concludes a paper in the *Med. Press*:

"To give examples of abortive treatment by germicidal remedies, I might mention that of scarlet fever and diphtheria, where, by the administration of the biniodide of mercury every two hours, in solution of potassic iodide, those germs which have found an entrance to the circulation, and whose presence there is indicated by the scarlatinal rash and enlarged cervical and submaxillary glands, are rapidly followed and destroyed, with the grand result of rapid restoration to health, and the prevention of those fearful sequelæ to which multitudes have fallen victims."

#### Tuberculosis of Pharynx.

To the Medical Society of London, Mr. Lennox Browne showed a young woman, aged 20, married, and the mother of three children, who was the subject of tuberculosis of the fauces and pharynx, extending to the posterior wall of the larynx, and slightly involving the right arytenoid cartilage. The lung showed only incipient phthisis, but tubercle bacilli were plentiful at the seat of ulceration. The patient had been unable to swallow, but the dysphagia was cured by scraping the diseased surface, previously anesthetized by cocaine, and then applying the solutions of lactic acid (20, 40, and 60 per cent.) to it daily for three weeks. This plan had been recommended by Krause, of Berlin.

#### Antifebrin in the Royal Infirmary, Edinburgh.

Antifebrin has now been used for several months in the Royal Infirmary, Edinburgh. It was introduced by Professor Grainger Stewart shortly after the first account of its properties was published, and since then it

has been used largely in more than one ward. The antipyretic qualities of the acetanilide have been most thoroughly tested, and it now occupies a high place among the febrifuge resources of the Infirmary. More especially it has been proved superior to antipyrin, kairin, and thallin, in its freedom from accompanying disadvantages, such as the production of vomiting, rigors, and other discomfort, at the various stages of its action.

#### Trephining for Supposed Abscess of Brain.

Mr. James Black relates in the *Brit. Med. Jour.* the case of a young man who had had symptoms pointing to abscess connected with disease of the ear. Puncture of the mastoid cells having failed to relieve him, the skull was trephined one inch and a quarter above and behind the external auditory meatus, and the brain explored for the abscess. The wound was subsequently reopened, and further search made with a trocar and cannula, but with no better result. In spite of severe constitutional symptoms, the wound healed well with the exception of a small sinus, and the patient ultimately made a good recovery.

#### Chronic Cocaine Poisoning.

Dr. Buebler, of Lucerne, describes (*Brit. Med. Jour.*) two cases of chronic cocaine poisoning. The patients were a man and his wife, who had formerly been morphinists, and who took to cocaine by way of antidote. They gradually reached a daily hypodermic dose of the latter equal to 2 or 2.5 grammes. The prominent symptoms were incoherence of ideas and optical delusions. They saw everywhere (on their hands, beds, walls, etc.) small spots, worms, and the like, presenting incessant movements and changes in form. Absolute discontinuance of the drug was followed by complete recovery.

#### Calculus as the Cause of Perityphlitis.

A Swedish surgeon, Dr. Sigurd Lovén, has published the notes of a case of perityphlitis, followed by a tumor in the ileo-cæcal region, and abscesses opening over the coccyx through the abdominal walls and rectal walls. Ultimately a calculus was passed through the abdominal wound, weighing 79 centigrammes, and measuring 2.5 centimetres by 1.3 centimetres. It was composed of alkaline phosphate of lime. Dr. Lovén believes this had existed for a considerable period, and that its situation had been in the vermiform appendix.

**A Pleasant Vehicle for Cod-Liver Oil.**

The following formula, as given by "Heder" in the *Chemist and Druggist*, is said to give a delicious emulsion:

Yolks of two eggs.	
Powdered sugar,	4 ounces.
Oil of bitter almonds,	2 drops.
Orange flower water,	2 ounces.

Mix carefully, and add to this gradually an equal bulk of cod-liver oil.

**A Hint in Dilatation of the Œsophagus.**

In dilating strictures in the upper portion of the Œsophagus, Dr. J. Solis-Cohen finds the passage of instruments much facilitated by forcibly drawing the larynx and trachea forward between the thumb and fingers of the disengaged hand, at the moment that the obstruction is reached by the dilating instrument.

**"Rough on Rats."**

It may be well to bear in mind, says Professor Bartholow, that the popular poison "Rough on Rats" owes its efficacy to phosphorus. Being an oily or fatty preparation, when taken into the stomach its action as a poison is very rapid.

**NEWS AND MISCELLANY.****American Medical Association.**

The thirty-eighth annual session will be held in Chicago, Ill., on Tuesday, Wednesday, Thursday, and Friday, June 7, 8, 9, and 10, commencing on Tuesday, at 11 a. m.

"The delegates shall receive their appointment from permanently organized State medical societies, and such county and district medical societies as are recognized by representation in their respective State societies, and from the Medical Department of the Army and Navy, and the Marine Hospital Service of the United States.

"Each State, county, and district medical society entitled to representation shall have the privilege of sending to the Association one delegate for every ten of its regular resident members, and one for every additional fraction of more than half that number: *Provided*, however, that the number of delegates for any particular State, territory, county, city, or town, shall not exceed the ratio of one in ten of the resident physicians who may have signed the Code of Ethics of the Association."

Secretaries of medical societies are requested to forward, at once, lists of their delegates.

Also, that the Permanent Secretary may be enabled to erase from the roll the names of those who have forfeited their membership, the Secretaries are, by special resolution, requested to send to him, annually, a corrected list of the membership of their respective societies.

**SECTIONS.**

"The chairmen of the several sections shall prepare and read, in the general sessions of the Association, papers on the advances and discoveries of the past year in the branches of science included in their respective sections. \* \* \* \*"—*By-Laws*, Art. II., Sec. 4.

*Practice of Medicine, Materia Medica, and Physiology.*—Dr. J. S. Lynch, Baltimore, Md., Chairman; Dr. J. B. Marvin, Louisville, Ky., Secretary.

*Obstetrics and Diseases of Women and Children.*—Dr. F. M. Johnson, Kansas City, Iowa, Chairman; Dr. W. W. Jaggard, Chicago, Ill., Secretary.

*Surgery and Anatomy.*—Dr. H. H. Mudd, St. Louis, Mo., Chairman; Dr. A. M. Pollock, Pittsburgh, Pa., Secretary.

*State Medicine.*—Dr. Geo. H. Rohe, Baltimore, Md., Chairman; Dr. Walter Wyman, U. S. Marine Hospital, New York, Secretary.

*Ophthalmology, Otology, and Laryngology.*—Dr. X. C. Scott, Cleveland, Ohio, Chairman; Dr. J. H. Thompson, Kansas City, Mo., Secretary.

*Diseases of Children.*—Dr. DeLaskie Miller, Chicago, Ill., Chairman; Dr. W. B. Lawrence, Batesville, Ark., Secretary.

*Oral and Dental Surgery.*—Dr. John S. Marshall, Chicago, Ill., Chairman; Dr. A. E. Baldwin, Chicago, Ill., Secretary.

*Medical Jurisprudence.*—Dr. I. N. Quimby, Jersey City, N. J., Chairman; Dr. H. H. Kimball, Minneapolis, Minn., Secretary.

A member desiring to read a paper before a Section should forward the paper, or its title and length (not to exceed twenty minutes in reading), to the Chairman of the Committee of Arrangements at least one month before the meeting.—*By-Laws*.

*Committee of Arrangements.*—Dr. Charles Gilman Smith, Chicago, Ill., Chairman.

*Amendment to By-Laws.*—Create a new Section, to be known as the Section on Dermatology and Venereal Diseases.

As it is required to issue the programme at least one month before the session of this body, all who desire to read papers at the session to be held at Bedford, June 29, should at once forward the title and a brief abstract

of the same to W. S. H. Gump, Chairman Committee of Arrangements.

WM. B. ATKINSON,  
Permanent Secretary.

### A Colony of Lepers.

The Hawaiian letter in *Boston Bulletin* says:

"Touching at Molokai we were afforded an opportunity for inspecting the leper colony established there. Many of these unfortunates were found to be in the last stages of the disease. The sight of these poor creatures would serve to excite the curiosity of only the most morbid nature. Their cheerfulness, even when rendered incapable of locomotion by the ravages of the disease, is somewhat remarkable, while their number include many Europeans, the Chinese being by far in excess of all other nations.

"The disease is said to be rather constituent in character than the result of cutaneous inoculation, as might be erroneously supposed. Science, however, has not been enabled to do much toward relieving the sufferings of these people, although their wants appeared to be generously provided for through the liberality of the government and that of foreign residents. The disease is contagious, while the hopeless misery of many of its victims in Hawaii would justly excite the pity of any beholder. One feature of the disease is the fact that there are many persons now living at Molokai who for years prior to their arrival there as patients had been living in various parts of the kingdom in utter ignorance of the appalling fact that leprosy was insidiously attacking the system.

"One instance in point was that of an aged Catholic priest, who discovered his deplorable condition only after an accidental breaking of a lighted lamp. It followed in his case that while removing some of the hot fragments in his effort to prevent any further damage, he found that he had lost the sense of feeling in his right hand. Instantly divining that he was afflicted with the dread malady, he heroically sought refuge among others at the leper settlement on Molokai, where I believe he died several years since."

### Scenes and Lessons of the Earthquake.

The *Brit. Med. Jour.* says:

The graphic accounts which refugees from the Riviera have brought to London of the scenes at Nice and Monte Carlo during the earthquake gave a vivid impression of the gruesome terror of the situation, and the ten-

dency which all such panics have to bring out the brute element in man. *Sauve qui peut* was the prevailing sentiment; and "the devil take the hindmost" was only in too many cases the corollary which the impulse of panic added. The scenes to be witnessed were made up pretty equally of the painful, the disgusting, and the ludicrous. Such a stampede of respectable and distinguished half-naked fugitives of all ranks has not been witnessed in our time. Fear and a selfish impulse of self-preservation appear in too many instances to have been the ruling sentiments; but happily also some of the higher traits of character were shown, and amidst stories of the most brutal selfishness and unreasoning panic it is a relief to hear of a few Englishmen who spent their whole time in calming the fears, aiding the immediate necessities, and relieving the distresses of the women and children. It is painful to be told that the first train from Monte Carlo was wholly filled with men, carrying only one lady, and for her a seat was secured only by her husband, who knocked down some forcibly intruding claimants and defended by main force the seat which he secured for his wife. The invalids appear to have suffered much from the cold, and in some phthisical cases hæmoptysis occurred. The sad story of after-suffering remains to be told; meantime, the visitors have reason for congratulation that they have emerged from so terrible a situation with so little injury. It will be long before the Riviera will altogether recover from the shock to confidence which this disaster has given. In the reconstruction which must necessarily follow, it is to be hoped that scientific attention will be given to the system of drainage. In many places, it is stated, the drains and water-supplies will need to be partially reconstructed, and it is to be hoped that a better system will be adopted than that which at present exists.

### A Physician's Disappearance.

A dispatch from Clifton Springs, N. Y., March 12, says:

"Dr. James McGammon, one of the physicians at Dr. Henry Foster's Sanitarium here, has disappeared in a very unaccountable way. He took a train for Rochester to see a sick friend, but inquiries show that the friend was not sick, nor had he seen the doctor. Dr. Gault, chief physician at the Sanitarium, received a letter from him last Sunday stating that he was then down the bay on his way to Europe, and that he would

write his wife immediately on his arrival in London. Inquiries in New York show that Dr. McGammon's name was not on the register of any outgoing steamer.

"The doctor was young, of unquestioned truthfulness and integrity, cheerful, bright, kind, sympathetic, and beloved by the faculty, help, patients, and villagers. He was a leading member of the Young Men's Christian Association, and never drank a drop of liquor in his life. It is believed that he has been suddenly stricken with insanity."

#### **Cholera in South America.**

The *Press* editorially says that cholera at the last advices from South America was waning, and it is to be hoped that our comparatively limited commerce with the Eastern coast of the continent is not to be hampered by quarantine precautions unless they absolutely necessary. The disease appeared last autumn on the west coast of South America, and Chili quarantined against it, the California State Board of Health also considering precautions necessary. It has not traveled far to the North, but taking, as might be expected, a course the reverse of that which it follows in the Northern Hemisphere, passed southward, and in spite of the precautions of Chili has followed the currents of trade across the South American continent. Mendoza and Tucuman, in the interior of the Argentine Confederation, have suffered severely, but the quarantine of the States has checked its progress, and at points like San Luis, midway between Chili and Buenos Ayres, its ravages have been few. Business at Buenos Ayres has revived as the fears of an attack have lessened and unusual prosperity has attended the opening of the year.

#### **A Young Epicure.**

A Boston lady, whose sister lives in Georgia, and whose mansion there is overrun, like every other big Southern residence, with black servants, receives frequently from her odd stories of these always funny people. Her stout colored cook, a charmingly loquacious person, has two small boys, who serve as errand bearers and personal servants to the lady of the house. One of these boys, whose name is Ivy, has a devouring passion for molasses, and not only decorates his countenance with it on all possible occasions, but cannot possibly eat his food without it. One day lately Ivy was served with some bread and honey at his lunch in the kitchen, and promptly called for molasses. "Land sakes!"

said his mother; "fo' to put on de bread 'n' honey?" "Sartin', mammy." "Lan' ob de livin' ef dat boy Ivy had de Angel Gabr'el sarved up on de table, he's ask right off fo' de 'lasses to put on him!"

#### **The International Medical Congress.**

J. J. Chisolm, M. D., of Baltimore, Md., has been appointed President of the Section of Ophthalmology of the Ninth International Medical Congress, in the place of Dr. E. Williams, who was compelled to resign on account of ill health. Judson B. Andrews, M. D., Superintendent of the Hospital for the Insane, Buffalo, N. Y., has been appointed to the office of President of the Section of Psychological Medicine and Nervous Diseases, made vacant by the recent death of Dr. John P. Gray. These are excellent appointments, both parties being widely known and eminently well qualified for the respective positions assigned to them. No vacancies now remain in the list of chief officers of the preliminary organization of the Congress or of its Sections; and our information from all departments is of the most encouraging character.

#### **Detection of Blood-Spots on Iron.**

Dr. Dannenberg contributes some valuable data on detection of blood-spots on iron. Blood is easily proven on ordinary surfaces by means of the crystal of haemine, but when blood-spots on rusty iron are to be examined their detection is not so simple a matter, as the iron-rust seems to form a combination with it. Dr. Dannenberg, however, states that if a few drops of a 10 per cent. solution of caustic potash be placed on the spot, and thus loosened, the rust scraped off and treated with ammonium sulphide and water, and then handled according to the usual method, elegant extended rhombic crystals will be formed. He considers these as conclusive proof, and names them "Haemidin" crystals.

#### **Official Representatives to the Ninth International Medical Congress.**

It was announced several weeks since that Dr. Leopold Servais, of Antwerp, had been appointed by the Belgian Government as representative to the Congress at Washington. More recently we learn that Deputy Surgeon-General Jeffrey A. Marsten, M. D., of the British Army, has been designated a representative by his Government, and the Government of France, through the Acad-

emy of Medicine, has designated as representatives Drs. Charpentier, Dujardin-Beaumont, Léon Le Fort, Trélat, and Vallin. From all directions, at home and abroad, the indications of a very large and interesting Congress are of the most gratifying character.

#### The Ear as a Criterion of Character.

According to the *Boston Medical and Surgical Journal*, the ear affords a better criterion in estimating human character than any of the other features. An ear without well defined elevations and depressions indicates selfishness and want of delicacy of perception; the possessor of a thick, well-shaped, highly-tinted ear, set well forward, is usually ungrateful, grasping, and lacking in depth of feelings; a thin ear indicates keen susceptibilities; a projecting ear, alertness; a broad ear is more coarsely practical. The perfect ear lies close to the head, is gracefully rounded with pretty curves, strong lines, and firm, delicately tinted cartilage.

#### A Simple Test for Butter.

There is a qualitative test for butter so simple that any housewife can put it into successful practice (*Scientific American*). A clean piece of white paper is smeared with a little of the suspected butter. The paper is then rolled up and set on fire. If the butter is pure, the smell of the burning paper is rather pleasant, but the odor is distinctly tallowy if the butter is made up wholly or in part of animal fat.

#### The International Medical Congress.

The item appropriating \$50,000 for the Congress was placed in the Sundry Civil Appropriation Bill, and was therefore, we presume, passed. If so, this sum will be a great help in promoting the success of the Congress. Several steamship lines have reduced rates to \$80, \$90, and \$100 for the round trip across the Atlantic.

#### Mr. Beecher on the Act of Dying.

Mr. Beecher was once asked by one of his myriad of correspondents: "How shall I feel when I come to die?" The great preacher replied, characteristically: "You will probably feel stupid," referring to the kindly provision of nature in benumbing the faculties when putting her children to their last sleep.

#### Personals.

—Dr. William Goodell resigned recently the post of Physician-in-Charge of the Preston Retreat, which he has held for twenty-two years. Dr. Joseph Price was elected as his successor.

—The late Rev. Henry Ward Beecher's body was placed in a vault in Greenwood Cemetery. The services were quiet. The dead preacher's will bequeathes his estate to his family.

—Dr. William A. Hammond will open the April *Popular Science Monthly* with an article entitled "Brain Forcing in Childhood." The paper gives a picture of the evils of the book-cramming process, and contains a plea for fewer studies, more direct contact with nature, and less of the intervention of books.

—Dr. Leeds, of Lincoln, Ill., offered \$5 to the Ladies' Missionary Society if twenty or more young ladies would sit together two hours without speaking. Twenty-six won the money, in spite of efforts to make them talk.

#### Items.

—Senor Don Dr. Rodolfo del Castillo and several other practitioners in Cordova, are forming a local Spanish society of Hygiene.

—"Physician, heal thyself," jocularly said a rich man to the doctor as he came into his office. "Thanks; that is what I propose to do," replied the doctor, presenting a bill for \$200. He went out well healed.

—M. Courbarien, intern of the maternity department of La Charité, Paris, died recently from typhoid fever at the early age of twenty-eight years. He was a man of much promise, and was highly esteemed, as evidenced by the testimony given by Dr. Budin, in his speech on the occasion of the funeral.

—Mr. J. S. Morgan, the well-known American banker in London, has promised the munificent sum of \$50,000 in aid of the funds of Guy's Hospital, on condition that the \$500,000 required to put the institution into a state of thorough efficiency be secured by May 1.

—A case of myxœdema was exhibited at the Berlin Medical Society by Professor Senator on February 9. He remarked that this was only the second case observed in Berlin, the other having been reported by Dr. Riess at the end of last year. Together with two cases described by Professor Erb, of Heidelberg, this case made the fourth reported in Germany.